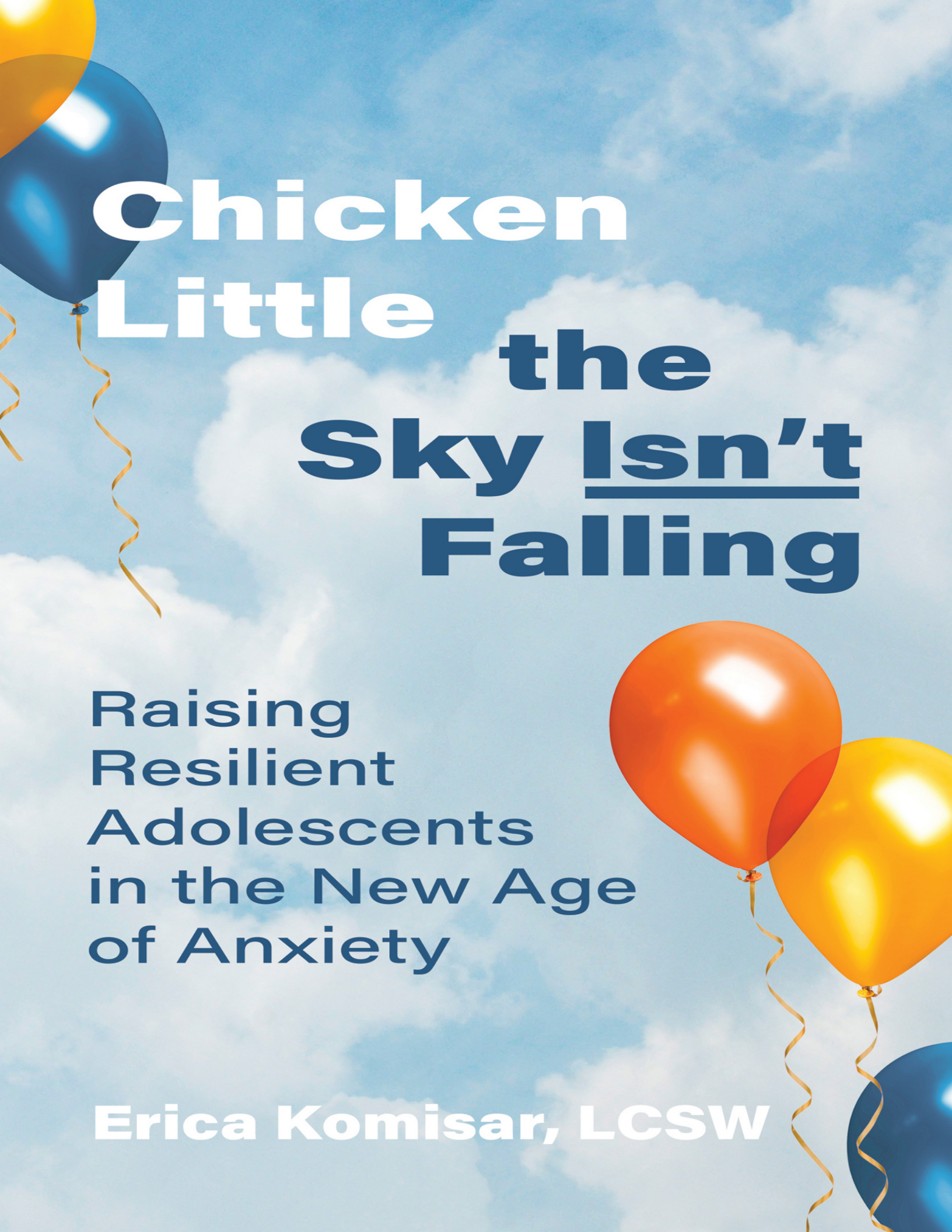




Chicken Little the Sky Isn't Falling

**Raising
Resilient
Adolescents
in the New Age
of Anxiety**

Erica Komisar, LCSW

Praise for *Chicken Little, the Sky Isn't Falling*

“Chicken Little may be the most important resource for parents of kids struggling with anxiety and depression. While other books describe these illnesses, Erica shows us what to do. Brilliantly written and clear, she calms worried parents. If you are concerned about your kids at all, you must read this book.”

—**Meg Meeker, MD**, pediatrician, parenting expert, podcast host, and best-selling author of *Strong Fathers, Strong Daughters*

“Raising adolescents today is tougher than ever. With science, wisdom, and heart jumping out of every page, *Chicken Little* is the ‘owner’s manual’ parents can’t be without.”

—**Randy Tobler, MD**, ob/gyn and host of The Randy Tobler Radio Show

“Chicken Little, the Sky Isn't Falling will help any parent navigate our anxious age. Everything seems to be stacked against the mental health of our children and teenagers. But, in reality, there is hope. Read this excellent book to learn what power you have as a parent to raise them to be resilient, happy, and free.”

—**W. Bradford Wilcox**, director of the National Marriage Project, senior fellow at the Institute for Family Studies, visiting scholar at The American Enterprise Institute

“Many parents are confused and bewildered by what is happening in the lives of their teenagers. They want to help but feel utterly ill-equipped to do so. This book teaches parents that you can still make a difference and give your teen or young adult child a foundation of emotional security and stability that will help them weather the storms of adolescence. If you are a parent, grandparent, aunt or uncle, pick up this book and use it as a compass to guide you through these challenging times.”

—**Baroness Philippa Stroud**, CEO of the Legatum Institute, co-founder of the Center for Social Justice, member of the House of Lords

“Erica Komisar brings science, common sense, and humanity to bear on the question of how to raise children in our crazy time.”

—**James Taranto**, editor for *The Wall Street Journal*

“Erica Komisar’s highly readable overview of the challenges adolescents face in our modern world gives insight, encouragement, and hope to parents who struggle with their teens and young adult children. Her kind and gentle wisdom are palpable on each page and point families toward a plan for success.”

—**Robert C. Hamilton, MD**, pediatrician, podcast host, author of *7 Secrets of the Newborn*

“Look no further! Erica has once again provided parents and educators with a vital playbook to help adolescents navigate the challenges of today’s world. If you have had difficulty communicating with or felt disconnected from the teens and pre-teens in your life, then this book is for you. Erica explores many important issues and offers realistic options for support.”

—**Mary T. Cantwell**, educator, learning issues specialist, founder of Enriched NYC

“Erica Komisar has vast experience with helping families navigate the ever constant and complex currents of life. She has a wonderful way of balancing kindness with pragmatism, providing what will no doubt be one of the most important resources for parenting.”

—**Eric L. Motley, PhD**, executive vice president and corporate secretary, The Aspen Institute

“Erica documents the science and the solutions needed for parents to help their adolescents overcome the unprecedented pressures they face today. What’s more is that her work is a

necessary prescription for how to better shape public policy and schools and can reduce the many barriers to having healthy kids and families.”

—**Jeanne Allen**, founder and CEO, The Center for Education Reform

“If every parent put Erica’s gentle, apolitical, and commonsense guidance and education to use, America would be deluged with happy, healthy families. I cannot say enough about Erica’s work. Make it part of your parenting journey and you can’t go wrong.”

—**Suzanne Venker**, relationship and life coach, author, podcast host

“Kids have more material advantages and less spiritual advantages than any previous generation. Erica helps parents navigate between these two poles. Her insights are both practical and inspiring. They very well might save your child, your marriage, and, at the very least, your sanity.”

—**Dennis Prager**, nationally syndicated radio talk show host, founder of Prager University, *New York Times* bestselling author

“Erica Komisar is one of today’s most important, provocative, and commonsense voices on crucial issues of parenting and relationships. Her insights and arguments always deserve serious attention.”

—**Michael Medved**, syndicated talk radio host and *New York Times* bestselling author

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To the love of my life, Jordan, whose belief in me, encouragement, and admiration have given me the courage to express my ideas honestly for the good of children, families, and society. And to my children, Bryce, Jonas, and Sofia, three extraordinary human beings, whose love is the inspiration for this book.

Acknowledgments

I want to thank:

Sydney Miner, my partner and collaborator, for believing in me, for her sensitivity, beautiful spirit, and talent at writing and interpreting my ideas.

My agent, Jane von Mehren, for her guidance, perseverance in making sure this book found a great home, and believing in the books that make a real difference in changing people's lives for the better.

Camilla Michael, my editor at HCI, who wholeheartedly believed in the message of this book from the very beginning. I feel so grateful to Camilla for making this important book a reality.

Lewis Leone, my editorial and research assistant, an inspired clinician in training, who has stood by me for years supporting my work. I am grateful every day for his talented writing, sensitivity, and emotional support as well as logistical support.

George Anne Ryan, my social media coordinator, without whom I could not deliver my ideas to a larger audience. Thank you for your creativity, persistence, protection, and loyalty all these years.

My research assistants Brad Riew and Kaley Davis, whose curiosity, diligence, competence, and intuition made this book a substantial, academically supported guide for families.

Baroness Philippa Stroud and the Legatum Institute for their unwavering friendship, encouragement, and support for my work to make an impact on creating a better world for children, parents, and families.

James Taranto, my editor and friend at the *Wall Street Journal*, whose support of my ideas and advocacy for children has improved the lives of so many families.

Joshua Greenman, my editor at the *New York Daily News*, who has supported my ideas and my writing for many years.

Michael Toscano, Brad Wilcox, and Alysse ElHage at the Institute for Family Studies, for giving me a home as a contributing editor and helping me to make a difference in bettering the lives of families.

My family of support at Fox 5 News New York including Lew Leone, Ernie Anastos, Donna Sweeney, and Sharon Crowley: thank you for including me as one of your experts all these years and giving me a larger audience for my work.

All the advocates for children who have given my ideas a megaphone, including Cardinal Timothy Dolan, Dr. Meg Meeker, Dr. Robert Hamilton, Dr. Randy Tobler, Michael Medved, Dennis Praeger, Jeanne Allen, Suzanne Venker, Richard Davies, Craig Sanders, Pauline Brown, Noam Dworman, Jennifer Grayson, Megan McCue, Claire Paye, Carolina Allen, Lynn Walsh, Madeleine Wallin, Caroline Hogg, Yaakov Galen, Kelly McDaniel, and Jordan Goldrich.

Mary Cantwell and Natalie Williams, whose support of my clinical work with families focused on social-emotional development from Garden House Schools has given me a great gift and a place to call home for many years.

My friends and colleagues at the Tennyson Center for Children, including Ned Breslin, Megan Vogels, and Claire Morrow, who have supported my work.

My friend Eric Motley from the Aspen Institute, who continues to provide me with not only his love but support for my work.

My friend and colleague Katherine B. Stevens at the American Enterprise Institute, for supporting my work and being an advocate for children.

The Contemporary Freudian Society, which has provided me with a community, but more importantly with the opportunity to teach adolescent development over the years and the privilege to help train young psychotherapists.

Introduction

I wrote this book because so many of my clients and friends asked me for a comprehensive guide to parenting a teenager in this stressful time when anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD) are on the rise. Even if you do everything right and you and your family have a warm and loving relationship, many aspects of an adolescent's daily life are stressful enough to tip the balance from health to distress.

The world your children live in is more complicated, more intense, more pressured academically and socially, and filled with more choices and pitfalls than the one in which you may have grown up. We give our children the gift of resilience to the stress of navigating the shoals of adolescence by loving them, accepting them, listening to them, and most importantly understanding them. It is the understanding that makes the difference between a child who feels supported versus one who feels alone. I hope this book helps you to understand your adolescent child better.

You may be tempted to read only parts of this book and skip the chapters you feel do not apply to your family. In my practice and in the schools I consult for, many of these issues are universal and have touched many families I know to varying degrees.

You may say, “My child will never have an addiction,” or, “My child doesn’t have an eating disorder.” I encourage you to read the entire book, even though it may not apply to you now or ever and even if some of the chapters make you feel uncomfortable. Your child may not have a technology addiction, but they may struggle with regulating technology. Your child may not have an eating disorder but may be preoccupied by body image. Your child may not suffer from depression or anxiety at the moment, but they are vulnerable, as are all children, to mental health issues.

We know that having mental health challenges is not uncommon. Many adolescents will experience mental health challenges at some point, and as a parent you want to be prepared to know how to support them. Knowledge is power, and that power is critical to helping your child get through the challenges, losses, and traumas of adolescence.

As a parent, you have the power to influence, educate, and impact your child’s emotional health well into their young adult years. By using this book as your guide, I am certain you can be a beacon of hope, change, and mental health for your child.

CHAPTER 1

THE NEW AGE OF ANXIETY

Adolescence has always been a time of emotional turbulence and change. But teenagers now face a more challenging road to adulthood than previous generations did. In today's rapidly changing world, economic, political, and environmental crises occur daily, and a good education does not guarantee you a good job or economic stability. Feeling unsafe and uncertain is the new reality, and hate crimes and violence are at an all-time high. Kids no longer feel like the grown-ups in charge are capable of protecting them or know how to fix things. The belief that there is room for everyone to succeed has been replaced with a realization that the world's resources are limited and not everyone will get their fair share.

Adolescence has always been a complicated mix of hormones, social stress, parental expectations, and internal criticism. Yet today's adolescents are also facing new pressures from technology and increasing pressure because of the scarier world we live in, turning that complicated mix into a boiling pressure cooker. And, like a pressure cooker, there is always the danger that things can explode. Parents are anxious and justifiably worried about their adolescent children, many of whom do not seem to be on the way to becoming functional, responsible, or resilient adults. In fact, while many of us have long believed that adolescence essentially meant the years between twelve and eighteen, according to adolescent

researcher Lawrence Steinberg, adolescence is now thought to begin as early as nine or ten, and end later, at around twenty-five. Based on the young adults I see in my practice, many of them are still struggling with adolescent conflicts even into their thirties. In fact, the neuroscience behind social-emotional brain development has shown us that adolescence is the second most turbulent and critical window of brain development; the first is from birth to three.

We are asking children to handle more—more stress, more stimulation, more pressure, more choices, and more decisions—without giving them a secure foundation of support, emotional security, and real and meaningful connections to cope with the emotions that come with these challenges. Then we wonder why our kids collapse when the emotional, social, and hormonal storm of adolescence hits.

Being a teenager in the age of anxiety is scary. Being a parent of a teenager is scarier. Our children may *seem* more together, more confident, more independent, and higher achieving than we were; but in fact they're more anxious, lonely, depressed, insecure, emotionally fragile, and less resilient to stress. They wake up every day to a less secure world and an environment with more political and economic instability, fierce competition for fewer jobs, changing career paths, unrealistic expectations of perfectionism, more social and academic pressure, more emphasis on status and living an Instagram lifestyle, and more social conflict. They listen to the endless droning of hysterical cable television hosts and read the headlines about climate change and end-of-the-world scenarios, the possibility of nuclear war, rampant school violence and shootings, and people famous for being famous flaunting their wealth and “fabulous” lives on social media.

It is also a more challenging time to be a parent to an adolescent. The messages parents get are confusing and contradictory:

- Don't be a helicopter parent/Monitor their academics and social life.
- Encourage their independence/Insist they do things your way.
- Be their friend/Be an authority figure.

It is difficult for most parents to sort through which of these messages are valid and which to ignore. Parenting an adolescent is not a binary, either/or proposition. In a more child-centric approach, what works for you and your family depends on your individual child and their needs.

An Epidemic of Mental Disorders

Statistics from the National Alliance on Mental Illness (NAMI) show that one in five teenagers have or will have a serious mental illness. This includes depression, anxiety, ADHD, and addictions of all kinds. A study published in *Pediatrics* looked at drug use trends in young people ages twelve to twenty-five from 2005 to 2014. The number of teens who reported a major depressive episode jumped from 8.7 percent in 2005 to 11.3 percent in 2014; young adults who reported a major depressive episode jumped from 8.8 percent to 9.6 percent. That's a 37 percent increase in less than ten years. Between 2012 and 2015, depressive symptoms rose by 21 percent among boys and a staggering *50 percent* among girls. In fact, in 2018 the American Academy of Pediatrics recommended that youth ages twelve and up be screened for depression at their annual well-child visit.

There has been a 400 percent increase in adolescents and young adults being prescribed psychopharmacological medication from 2005 to 2008. A 2017 report from the National Institute on Drug Abuse noted that 14.4 percent of young adults ages eighteen to twenty-five and 4.9 percent of teenagers from the ages of twelve to seventeen reported they used prescription drugs like Adderall and Vicodin for nonmedical reasons. Even more frightening, according to the Centers for Disease Control and Prevention, the suicide rate for children ages ten to fourteen *tripled* between 2007 and 2017 and rose 75 percent for fifteen- to nineteen-year-olds between 2007 and 2017.

Why Is This Happening?

There is no single cause of this epidemic that we can point to; it's a perfect storm of factors, including cultural and societal stressors, a change in parenting styles, and socioeconomic dynamics that has made vulnerable teens and young adults even more vulnerable.

Children are not born resilient to stress or adversity. Every house has to have a solid foundation to stand strong in the face of a storm. The foundation of emotional security is a healthy attachment to a primary caregiver. If infants and very young children learn that they can depend on their parent or caregiver to take care of their physical and emotional needs, and soothe them when they are distressed, they will have a strong and secure emotional foundation. The rise of two-parent working families who have to rely on inconsistent or group care means that very young children often do not get the kind of sensitive, responsive care that they need. These children are more emotionally fragile because they have had to become emotionally and defensively independent too early.

There are two critical periods in a child's life when these emotional, or right-brain connections, are made. The first period is from birth to age three, and the second is during adolescence, from nine to twenty-five. That's good news and not-so-good news.

The less good news is that emotionally fragile young children become emotionally fragile adolescents if their losses, conflicts, or symptoms are not addressed early. They are not just more likely to suffer from anxiety and depression but often turn to addictive behaviors and substances to self-medicate.¹

The better news is that this second critical developmental window of adolescence offers parents another opportunity to connect with and repair their relationship with their adolescent child while promoting emotional stability and resilience.

What Does Attachment Have to Do with It?

In an age of individualism and parents either having to or wanting to return to their own lives, work, and interests as quickly as possible, it is the attachment process that suffers the most. Attachment between parent and child forms the basis of emotional security, and that gives teens the ability to cope with stress.² Many parents believe that attachment occurs immediately after birth or in the first few months and then they are all set: their child is attached and emotionally secure. This is a misunderstanding of the process.

Bonding, which can take place immediately after birth, is not attachment. Attachment is, as the father of attachment theory John Bowlby says, “the emotional scaffolding” on which a child's emotional security and resilience are built. A mother may bond with her baby right away or in the first few days after birth. Secure attachment is a long process that takes place

over the first three years of a child's life. When a mother or primary caregiver is physically and emotionally present as much as possible and responds to a child's needs and distress by nurturing and reassuring them, they provide a framework for their child of what to expect from the environment and relationships in the future. Will a mother or caregiver be there when they are scared, sad, angry, or fearful? Is their caregiver a reliable source of comfort? If the answer is yes, a child internalizes that sense of security. If something goes awry in the attachment process, and a child lacks the sense of emotional safety, they are more likely to develop what mental health professionals call an *attachment disorder*. Children with an attachment disorder see the world as an unsafe and unreliable place. They have trouble with self-esteem, forming healthy relationships, and regulating emotions.³ The toddler who still cries after six weeks when his mother leaves him at nursery school is an example. These children often still have the same attachment disorders in adolescence and young adulthood.⁴ They are less equipped to deal with the new realities of this stressful world. Many of the teens breaking down and experiencing crushing anxiety suffer from attachment disorders, which may not be evident to their parents.⁵

The Separation Process and Premature Independence

The dramatic increase in teens and young adults suffering from anxiety can also be attributed to the mishandling of the separation process. Margaret Mahler talks about "rapprochement" as a young child's ability to practice independence while still having their secure love object, usually their mother, to return to and emotionally refuel so that they can toddle off again to explore. The ability to internalize their

mother or primary caregiver as a source of strength and security when they are distressed does not happen until a child reaches the age of three, and only if their mother or primary caregiver has been present enough both physically and emotionally. Separation is often pushed too early and in such a rushed fashion that children do not get to practice independence in a slow, meticulous, and somewhat cautious manner. This push for early independence is backfiring, leaving our kids less able to cope with the stress of a more complicated and overwhelming environment.

Our culture expects premature independence and self-sufficiency from our very young children. This demand that our kids grow up faster puts them at more risk for anxiety and depression later in adolescence. When we leave our children too early, before they have developed a healthy sense of security and self-esteem, when we sleep train them too early, potty train them too early, or expect them to be emotionally self-sufficient or to handle frightening or strange new situations or people without us too early, we are creating more fragile human beings. “Ferberizing,” a popular method of sleep training, is not meant for children younger than six months, but parents often use it on babies as young as three months. Even Dr. Richard Ferber, who developed the program, has said that it doesn’t teach children how to fall asleep on their own; it simply keeps parents from their children and lets the children “work it out” by themselves. A *New York Times* article noted that some parents were encouraging their children to potty train as early as six months, before children develop the sphincter control necessary to learn toileting.

Children may adapt and become more self-sufficient, but this often comes at the expense of that deep-seated feeling of security in adolescence. Their seeming independence is a

defense—a kind of emotional callus that allows them to cope with society's and their parents' expectations. Because these defenses come from fear and insecurity, rather than developing naturally and on a developmentally appropriate timeline, they're like the little pigs' houses of straw or twigs that collapse in the face of the storms of life.

What Does Genetics Have to Do with It?

Serotonin is used by the brain to feel and regulate pleasure. Research by Grazyna Kochanska at the University of Iowa found that children born with a short allele—a gene mutation—on their serotonin receptors are more susceptible and more reactive to stress, as well as more vulnerable to mental health issues like depression and anxiety. For reasons that scientists still do not understand, an increasing number of babies are being born with a genetic sensitivity to anxiety and depression. This tendency can be mitigated in the first three years of a child's life by sensitive and empathic nurturing and the consistent emotional and physical presence of their primary caregiver or mother. A child who receives that kind of care has as good a chance of growing up mentally and emotionally healthy as a child born without that gene. During adolescence, parents have a second opportunity to help their sensitive child by lessening the effects of stress and anxiety.

What Else Makes Adolescents Vulnerable?

A number of developmental issues can make adolescents more vulnerable to mental and emotional instability. While some of these issues and internal conflicts have always been a normal part of development, the additional pressures of

contemporary culture, on top of the usual challenges of growing up, can create a tipping point, even for healthy kids.

Like toddlers, adolescents have trouble regulating their emotions. (I talk more about the brain science of why this is in Chapter 3.) While a teen may not throw themselves on the floor in a tantrum, parents of adolescents are very familiar with the sound of a slamming bedroom door. Also, like toddlers, early and middle adolescents are present-oriented and struggle to grasp the concept of a different future. Many cannot see beyond the emotional pain and stress they feel in the moment; their feelings of distress feel permanent. This puts them at risk for despair, hopelessness, self-harm, and suicide.

Separating from parents is a necessary part of becoming an adult. However, in separating, adolescents—and this includes young adults—can feel like they're losing the source of security and comfort they've relied upon their entire lives. They don't yet understand that independence is not binary and that they can ask for help without compromising their independence; this is a powerful source of ongoing tension and distress.

Becoming an adult means figuring out who you are as an individual. It involves taking stock of all the things your parents represent and believe in and deciding what you believe in, what you don't accept, and who you are as a person separate from your parents and family. This obviously can create tension and often conflict between parent and child. In a healthy family dynamic, there's the same kind of emotional refueling that occurs in toddlerhood—a slow and organic process of rapprochement. If parents feel rejected, however, they may be quick to reject or push their child away during this process. An adolescent may reject their family because they are afraid of getting “stuck” and not wanting to leave. In both cases, this can delay or impair their healthy development.

It's a Bigger and More Competitive World Than You Remember

Going from feeling small to feeling big is an important milestone for children and adolescents. Not too many years ago, people lived and went to school regionally. When they graduated from high school, college, or trade school, they were confident they could find a job to support themselves, usually close to their family. They were able to be big in a smaller, more manageable world where they had a sense they had some control over their future.

Today, the world has gotten much bigger. Twenty-eight percent of high school seniors go to college 100 to 500 miles away from home, and almost 16 percent go to school more than 500 miles away.⁶ Teens and young adults are not only competing with those immediately around them; they are competing with others around the country, and sometimes in other countries, who want the same education, opportunities, and employment. As early as middle school, children become fully aware of what is at stake; even at this tender age their academic, athletic, or artistic accomplishments matter and are being judged. They don't just feel the pressure to do well, but to be perfect as they build their résumé for college. It doesn't feel like being good enough or normal cuts it anymore.

We have become a society that values achievement and material excess as indicators of a person's value. We spend our time focusing on being busy and accumulating more possessions rather than spending time building and nurturing relationships. Parents who feel this pressure pass it down, consciously and unconsciously, to their children. This overemphasis on high achievement and material success leaves adolescents constantly questioning their worth and feeling like

they have to prove their value through what they do, how much they make, and how much they accumulate rather than who they are.

Carol and Joseph were worried about their sixteen-year-old daughter, Charlotte. Smart and hardworking, Charlotte attended an academically pressured gifted and talented high school and was doing well, but she suffered from intense anxiety, insomnia, and occasional panic attacks.

Charlotte and her older sister, May, had competed for everything, including their parents' attention, since they were young. May was just finishing her freshman year at an Ivy League college and "excels in everything she does," said her parents.

Carol and Joseph were successful professionals in their respective fields of banking and medicine. They had high expectations of themselves and their children. "We expect the best from them," Joseph told me, "and don't really tolerate less." Carol said that May thrived under that pressure, but Charlotte clearly didn't. Charlotte had always been a "good girl" who tried her best to do what her parents asked of her but had always suffered from separation anxiety and was afraid of everything from the dark to dogs.

Carol and Joseph said that they had been telling Charlotte to take the pressure off herself. However, they also needed to be aware of their unconscious expectations, and how they communicated those and their own anxiety and impatience to her. If Charlotte had struggled on a test, for example, grilling her about whether they should get her a tutor or how this would affect her transcript for college sent the message that she had disappointed them, fueling her anxiety.

As a result of working with me, Carol and Joseph concentrated more on their conscious and unconscious messaging to Charlotte. They encouraged her to engage in more social and fun activities rather than schoolwork alone. Rather than focusing on performance, they were able to recognize that Charlotte had different academic strengths and weaknesses than May, and they helped her look for colleges that would best suit her needs rather than pushing her into a more competitive academic environment that would only exacerbate her anxiety.

Favoring Left-Brain Development

The long-term effects of the increased emphasis—at all socioeconomic levels—on left-brain, or cognitive, development before right-brain, or social-emotional, development increases the likelihood of mental breakdowns in adolescence.

Think of social-emotional development as the socks you put on before you put on your cognitive shoes. You need socks to protect your feet from the rough edges of the shoes or you get

blisters. The movement to replace unstructured play with reading and math skills, to teach children sign language before they can speak, and to use flash cards to enhance cognitive development sacrifices their social-emotional development based on play, which is critical for the mental health of children and adolescents.

Sensory Overload

We all know what happens when you have an overstimulated toddler—crankiness, tantrums, meltdowns. They may become wild or zone out completely. We don't think of teenagers or young adults as being overstimulated, but they can be, and they are. It's not surprising, because we now know how similar the brain of a toddler is to that of an adolescent. When kids, no matter what their age, are overstimulated, they can't deal with what they're feeling or tell us what's wrong, so they act out. Sound familiar?

Exposure to explicit violence, sex, political and social instability, and end-of-the-world scenarios affects adolescents in ways we are just beginning to understand. In the past, stronger societal and parental boundaries protected children; those boundaries were based on knowledge that children and younger adolescents are not emotionally capable of processing explicit exposure to violence and adult sexual behavior and are not able to cope with the effects of drinking and using drugs at a young age. Even caffeine was off-limits when I was a child.

A study in the November 2013 issue of *Pediatrics* discussed how media overexposure can affect children's mental health. The journal reported that R-rated films of the 1980s like *Terminator* or *Die Hard* would likely be rated PG-13 today. A movie like *The Hunger Games*, aimed at the adolescent

demographic, contained more violence than either of those films.

Not only that, but most kids have unsupervised access to media at some point; they're almost certain to be exposed to pornographic and violent content. Vulnerable young people who haven't developed emotional coping skills or haven't had honest discussions with their parents or caregivers may be overwhelmed by the excessive aggression, emotional abuse, and sexual content. Exposure to such explicit and sometimes violent pornography impacts how teens and young adults experience intimate relationships in the real world. There is a new reality of the normalization of perversion and emotional detachment rather than connection, and the volatile and confusing combination of sex and violence makes real relationships more confusing.

Connected but Alone

Technology and social media have become societal addictions across all age, economic, and social boundaries. Today, some 95 percent of American youth own cell phones or have access to one, according to a Pew Research Center study. Like most of us, adolescents are spending increasing amounts of time on their devices, sometimes to the exclusion of much-needed human contact. According to the Pew study, 45 percent of teens in 2018 reported that they use the internet "almost constantly," compared to 24 percent in 2014.

The internet and social media use have had a corrosive impact on teens' ability to be alone and to deal with frustration. They have reduced teens' ability to focus and increased distractibility. The internet and social media have introduced superficial virtual communities that are replacing real family,

religious, and peer relationships, which contributes to the sense of isolation and inadequacy that many teens already feel.

It's all too common for teens who may be struggling academically or socially to turn to video games and technology. These virtual realities give them a way to escape feelings of loneliness, isolation, or otherness, and to numb the pain, anxiety, and depression these feelings bring. Mastering video games and participating in anonymous online communities make kids who feel ostracized and powerless feel competent and powerful. It lets them express their aggression and feel like heroes.

Contrary to what most people think, video games and tech addiction are symptoms of depression and anxiety, not the root problem. According to a recent Iowa State University study, 8.5 percent of American children and teens between the ages of eight and eighteen—that's roughly 3 million children—are addicted to video games. *The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)*, published by the American Psychiatric Association (APA), now includes a diagnosis of internet gaming disorder. Symptoms of pathological gaming include spending increasing time behind a controller, irritability when playtime is reduced, "escaping problems through play," skipping homework in favor of gaming, and stealing money with which to purchase additional games. This is not just a U.S. problem: the World Health Organization has added gaming addiction, or gaming disorder, to the latest update of its *International Classification of Diseases (ICD)*.

Increased use of technology also exposes teens—through movies, TV, and the internet—to adult behaviors like drinking, drugs (including caffeine), sex, and smoking at younger ages, which encourages early and premature experimentation. These

behaviors can disrupt brain development and leave teens without the emotional maturity or judgment to deal with the consequences.

Social media, which some children use as early as fifth grade, exposes children to the dangers of cyberbullying as well as cyber predators. According to the Cyberbullying Research Center, 33.8 percent of teens between the ages of twelve and seventeen have been the victims of cyberbullying, and 24 percent of those who have been victims of cyberbullying have had suicidal thoughts. The Pew Research Center found that 59 percent of American teens have been the victim of at least one of six types of online abusive behaviors. Ninety percent of teens believe that online harassment is a problem, and 63 percent say it is a major problem.

The values that social media has promoted—fame and fortune rather than deep and meaningful human connections and work—has driven teens who are already conflicted and confused toward empty and ultimately dissatisfying goals and outcomes. In a UCLA study, teens were shown to value fame and celebrity over anything else.

Because of the comparisons that social media encourages and the unrealistic standards of what it means to be “beautiful” or “cool,” and have a “good life,” anxiety, self-consciousness, and harsh self-criticism reign. Although these superficial values have always been a part of adolescence, they were a short and temporary developmental stop on the way to self-acceptance and emotional security. Now social media prolongs this period of self-involvement, self-consciousness, and insecurity, and teens and young adults often get stuck in a negative feedback loop.

The New Financial Instability

When older teens and young adults go out on their own, many are confronted with the new financial realities of our time: fewer stable jobs and little job security. As I write this, a recession caused by COVID-19 has sent unemployment numbers soaring, surpassing those of the Great Depression.⁷ After graduating high school or college it is that much harder for young adults to find a job that provides the financial security to live independently. Many live with multiple roommates or move home. In 2019, *Forbes* noted that 50 percent of college students surveyed planned to move home after they graduated. And of course, the pandemic drove those numbers even higher as remote schooling, remote work, and unemployment changed the economic picture dramatically.

It's Not Your Mother's Marijuana

Substances such as nicotine, alcohol, and drugs have always been available to teens. Today, however, they are more accessible and available to our children at a younger age. Drugs like marijuana are more potent, and more powerful prescription painkillers are widely used and abused. Vaping, which was marketed as a “safer” way of getting a nicotine fix, has addicted a new generation of users with its potent delivery system. Illegal pods containing THC and other street drugs have led to a spate of serious illnesses.

More teens and young adults are turning to self-soothing behaviors like drinking, prescription drug abuse, marijuana, and vaping. Vaping has become a full-blown epidemic. “Monitoring the Future,” a study conducted by the University of Michigan, surveys 50,000 eighth-, tenth-, and twelfth-grade students every year. They found that in 2016, one out of every

three high school seniors used a vape or e-cigarette, and one out of six high school seniors had vaped in the last month.

The glamorization of the drug culture and its antiheroes, like Walter White of *Breaking Bad*, have become part of popular culture. With the combination of a more pressured, stressful, and *overstimulating* environment and less overall adult supervision, it is more likely for teens to have anxiety, depression, and subsequent abuse of these substances. The National Center on Addiction and Substance Abuse published a study in 2011 that examined risk factors for teen substance abuse and addiction, including messages sent by adults that violence, underage drinking, and drug use are acceptable, and by the media that smoking, drinking, and drugs, even for young people, represent aspirational behaviors. The study found that three-quarters of high school students have used addictive substances, including cigarettes, alcohol, marijuana, or cocaine, and 90 percent of Americans who meet the medical criteria for addiction started smoking, drinking, or using other drugs before they were eighteen.

Media also plays a part. The more hours of TV an adolescent watches, the higher their risk of smoking and drinking; movies were also found to impact rates of teenage smoking and drinking.⁸ On TV, drug and alcohol use are often shown in a humorous light. While even G-rated movies depict tobacco and alcohol use, health messages about their use are rare. In teen-focused films, most teen characters who use drugs or alcohol rarely suffer negative consequences. Because these images are so prevalent, we may not even think about their impact on our kids. As they enter adolescence—when many of them will experiment with these substances—we must arm them with information and ways of coping with peer pressure and the

insecurities that often lead to substance use, abuse, and addiction.

Seventeen-year-old Steven was diagnosed with attention-deficit/hyperactivity disorder (ADHD) when he was seven. Steven had always been shy and anxious. He clung to his mother, Anne, at playdates, and cried when she and her husband, Bill, went out and left him with a babysitter. In circle time at nursery school and kindergarten, he would become agitated and overwhelmed, and his teachers would have to let him sit apart from the group to calm down.

The psychiatrist told his parents that Steven's ADHD was an organic condition and immediately prescribed Ritalin. The drug helped his attention issues but did nothing to deal with his underlying anxiety. When Steven was twelve, and with his parents' and doctors' approval, he stopped taking Ritalin because he felt jittery all the time. His attention issues seemed to have improved, but he remained a shy and anxious teenager. When he was fourteen, he started smoking marijuana as a way to dull his anxiety and was now smoking two or three times a day, every day.

Anne and Bill came to me because they were deeply concerned about Steven's drug use. When they told me about his ADHD and anxiety, I explained that anxiety and other emotional issues can be an underlying cause of attentional issues, and that ADHD is not usually an organic or constitutional issue, which is why I believe that play therapy for younger children and talk therapy for older ones should always be the first line of treatment to get to the bottom of the emotions that cause ADHD symptoms. Steven was smoking to self-medicate his continuing anxiety about not getting good grades or being successful, and about disappointing his parents. I told Anne and Bill that what we needed to do was to understand what he was so anxious about and help him deal with those emotions.

The first step was to calm his parents' emotions and behavior around Steven's smoking. Bill, due to fear about his son's addiction, would become aggressive and enraged when he found Steven smoking, and both parents' punished him frequently by grounding him. Steven lived in fear of his parents' wrath but was more afraid of his feelings of anxiety if he didn't smoke, so he continued.

Bill and Anne saw Steven's sensitivity and emotional regulation issues as "weak" and a reflection on them as parents. Bill's parents had been harsh disciplinarians and had expected Bill to deal with his emotional hurts himself. He expected the same of his son. Anne told me she was bored and anxious when she was on maternity leave. She suffered from postpartum depression and felt inadequate to take care of a very needy baby. Both parents struggled with their son's sensitivity.

Through their work in therapy, Bill and Anne learned to become more empathic toward Steven and to comfort him when he felt anxious rather than ignore his distress. They worked to accept that their son had challenges dealing with frustration and stress and would not necessarily follow the same path to college and business success that they did; his skills and interests did not have to reflect theirs. Steven was a talented guitar player and wanted to pursue a career in music. Rather than discourage his ambition or respond punitively, his parents helped him look into schools where a music major was possible.

They agreed to discuss the possibility of a gap year after high school, which would give him a chance to mature and spend time learning how to regulate his emotions without drugs. Steven agreed that his marijuana use was excessive and interfered

with his academics and social life and started therapy himself. He found that yoga and running helped manage his anxiety and was able to cut back to smoking once a day, then just a couple of times a week, and by the time he graduated high school, once or twice a month.

Too Many Choices

Teens and young adults are bombarded with a seemingly endless number of choices in everything from what to watch on TV to clothing, makeup, music, what courses to take in school, even their gender identity. Choice and the ability to choose promote self-esteem and autonomy. Too many choices create anxiety and the feeling of being overwhelmed. It's not empowering; it's paralyzing.

Children three to eight years of age dream of becoming a ballerina, a fireman, the president of the United States, a baseball hero. Eventually, their personal strengths and limitations begin to limit their choices. They love baseball but may not be the best at it, or they want to be a ballerina but may not have the body or aptitude. This acceptance of their strengths and limitations is part of maturing into adulthood. But messages from parents and society that you can do anything and be whatever you want do our kids a great disservice. They encourage narcissism and entitlement.

Whenever we make a choice, we give up other choices; this is a loss. However, this also deepens the experience of the thing to which we commit. By taking choices off the table one by one, a person is formed. The thought of having to choose between so many options—which may not, in fact, be real options based on one's abilities, interests, and connections—can be completely overwhelming. I have counseled many parents and many young adults who are in a state of panic over their “limitless

choices” and FOMO: the fear of missing out by choosing one thing over another.

Accepting your child as an individual with their own set of strengths and limitations is often the difference between an emotionally centered and an anxious teen. Adolescents are still open to the influence and approval of their parents. Even the most rebellious of teens feels influenced, perhaps unconsciously, by their parents’ desires. Parents can help in this process of self-discovery and self-acceptance by helping their children find their strengths and accept their weaknesses by allowing them to experiment with a variety of hobbies and activities without judging them on the outcome or their performance. Giving teens permission to try things without having to succeed or commit to them is critical to preventing anxiety. This also means remaining neutral or objective about their college and career choices.

Seventeen-year-old Lydia had always been acutely aware of what was expected of her in terms of academics and extracurriculars by her parents, Tamsin and Craig. She knew she was expected to get into a top college and had stuck to the strategy laid out for her by her parents and her college counselor. She had taken courses that they felt she should take; she had played the sports that her parents felt would help her chances of college admission. Lydia was a good student and a natural athlete, and she wanted to please her parents. The only—and most important—person she had not pleased was herself.

Now a junior in high school, Lydia felt squeezed into a box by her parents’ expectations. She hated playing soccer. She hated taking Latin and calculus, and she didn’t want to work for Habitat for Humanity in the summer to boost her résumé. What she wanted to do was to learn to play the piano, and to have time to read, and to write short stories. She didn’t care if the college she attended was in the top ten in the *U.S. News and World Report* survey. Afraid to tell her parents how unhappy she was, and what she really wanted for herself, she wasn’t sleeping well, got frequent migraine headaches, and started having panic attacks that sent her to the nurse’s office more than once.

Tamsin and Craig came to see me about their daughter’s distress. In our sessions, they became aware that what they wanted for their daughter and what she wanted were very different. By pushing her to do what was important to them, they prevented Lydia from discovering and expressing what was important to her. They realized that

they had displaced their own anxiety and drive onto their daughter, assuming that she was an extension of their own desires rather than a person in her own right.

In her own therapy sessions, Lydia developed more of a voice to express her own desires to her parents. In her senior year she dropped physics and economics and added music and creative writing to her electives. She left the soccer team and planned to spend the summer between high school and college writing and improving her piano skills. Lydia was accepted to a smaller liberal arts school in the Midwest that had a reputation for an interdisciplinary arts program. She became more and more comfortable asserting her wishes, and her parents learned to appreciate this new side of their daughter.

A Fractured Community

We need connection to grow and thrive. Communities used to be places where people knew your name. The local pharmacist knew your prescriptions by heart, the waitress at the diner didn't have to ask what you wanted for breakfast, and someone was always home to accept a package or watch your kids if you were late getting home from work.

A 2018 study by Chen and VanderWeele published in the *American Journal of Epidemiology* reports that children and teens do better in terms of their mental health when they are raised in a family with religious or spiritual practices, and yet the interest in organized religion continues to decline. Not only did religion and faith practiced in the home provide children with an emotional safety net, it also provided them with a feeling of community and sense of ethnocultural identity that supported them in times of adversity.

Teens have always needed a community of friends and peers to provide them with a bridge to healthy independence from their parents. Their "tribe" was a safe place for them to talk about their hopes and fears about their changing world, and provided a sense that as they separated from their family of origin they would not be alone. Today, the emphasis is on having hundreds of "friends" on Facebook or Instagram, which

means having many connections but not real friends. The presence of extended family, religious institutions, and other forms of “real” community have been replaced with superficial, empty, and fleeting contact, leading to generations suffering from loneliness and disconnection.

Adolescence and Loneliness

Social relationships are important throughout our lives, but at no time do these relationships seem to be quite so important as during adolescence. Children are spending less time with their parents and becoming very dependent on their friendships and romantic relationships and sensitive to the perceptions of their peers. Some teens navigate this new social world quite adeptly, but for others, adolescence can be a stressful, confusing social environment. For many teens, it can also be a very lonely one.

Nearly every teen experiences loneliness at some point. However, for some teens, loneliness is more than just a temporary feeling and can be a much deeper and more long-lasting state. A 2018 survey conducted by Cigna shows that Generation Z (born roughly 1997 to 2012) has the highest loneliness scores of any generation alive today. That’s a serious problem. Studies have shown that social isolation in teens is associated with decreases in self-esteem, increases in depression, and even increased risk of suicide.⁹

Loneliness is not just a difficult feeling; it is seriously detrimental to our physical health. Research shows that chronic loneliness and social isolation are associated with an increased risk of mortality to the same degree as smoking and obesity: in fact, chronic loneliness is as detrimental for your health as smoking fifteen cigarettes a day.¹⁰ Part of the reason loneliness

is so harmful is that people who are chronically lonely are locked into a perpetual state of fight-or-flight. This constant state of stress can be detrimental to a whole range of health issues, from cardiac to brain function.

Chronic loneliness can also affect the way the brain functions. Studies using brain scanning technology have shown that lonely people show less activity in the striatum, a reward-processing region, in social contexts. They also have changes in activity in an area called the temporo-parietal junction, which is active when thinking about other people's thoughts. Lonely people perform more poorly on tasks measuring semantic memory (recalling words, ideas, and numbers), processing speed, the ability to interpret what they see, and their perception of size and location of objects. Lonely people also experience more difficulty in self-regulating their own attention and emotions.^{[11](#)}

One of the worst effects of loneliness is that it can lock people into a feedback cycle in which they come to expect negative outcomes from social situations. They're more self-conscious in social situations, more judgmental of others, and afraid that others are judging them too, and those perceived judgments, even if they're not accurate, affect them more strongly. The result is that chronically lonely people may retreat from the social connections that they need most.^{[11](#)}

Here's the very good news: with all these environmental and internal stressors, you can still make a difference and give your teen and even your young adult child a foundation of emotional security and stability that will help them weather the storms of adolescence.

CHAPTER 2

EMBRACING NORMAL ADOLESCENCE:

A Three-Phase Adventure

Adolescence is a brave new world with new boundaries and new challenges for kids and parents. The boundaries for this period of development were formerly defined as beginning at age twelve and ending at nineteen. Now, because of technological advances that allow us to see the brain, as well as the most current neuroscience research, we know that adolescence can begin as early as nine and end as late as twenty-five.¹

Mental health professionals used to see adolescence as one continuous stage with clearly defined limits. Now we know that it is not just longer but has three phases: early adolescence (nine to thirteen), middle adolescence (fourteen to eighteen), and late adolescence (nineteen to twenty-five).² If you wanted to give each stage of the adolescence story a name, early adolescence would be *Exploration*, middle adolescence would be *Declaration*, and late adolescence *Confirmation*. Each stage is marked by unique developmental milestones emotionally, cognitively, and physically, and each stage has its own challenges for parents and kids. By understanding the changes that occur in each phase, parents can be most effective in supporting their children, especially when they are still living at home. This is usually from middle school through college, but

a parent still has some influence when a young adult is out on their own.

Adolescence is the second critical period of social-emotional brain development after ages zero to three. Knowing what you can and can't expect from your teen emotionally, physically, and cognitively can make these transitional years easier for everyone. Imposing unrealistic expectations of emotional maturity, focus, and decision-making on your teen can derail their development and interfere with your relationship.

Each young person is an individual and experiences adolescence in their own way. It is not a given that a child needs to reject everything about his parents and their lifestyle, and many teens express their struggles internally and in more nuanced ways.

If you and your child are having a difficult time, let me reassure you that it is not a reflection of a parent's competence if their child struggles with the challenges of adolescence. What matters is how you handle whatever reaction your child has to the struggle. Some of your child's behavior is not about you. Like toddlers, adolescents are asserting their independence and are often afraid of their own anger and strong feelings. If you are calm in the face of their emotional storms, it will be less fun for them to provoke you—and provoke you they will.

Early adolescents are trying to keep up with rapid physical changes and hormonal shifts while starting the process of separation while still being dependent on their parents. Middle adolescence is marked by struggles with gender and sexual identity, and an effort to find their "tribe" and fit in socially. The determination to separate from parents can sometimes take a dramatic turn. Late adolescents and young adults (my mother-in-law had a name for adult children: *chads* or *child adults*) work to consolidate their individual identity as adults in the

world, preparing to leave home—physically and emotionally—with a secure base beneath them and their future ahead of them. I discuss each stage in depth so that you can understand the underlying reasoning for your child's behavior and moods.

It is normal for teens to reject many of their parents' ideas and identity—religiously, culturally, even ethnically—in order to form their own sense of who they are in the world as separate individuals with separate identities. One of the ways an adolescent does this is to strongly identify with their peer group's culture, beliefs, and gestalt.

If you force your own views, beliefs, and tastes on your child, they may reject your views, and you, in a more dramatic and permanent way. But if you allow for the differences between you and your teen, you may ultimately find more similarities than differences. So if you like classical music, and your child likes indie rock, this does not mean that your child will not appreciate classical music (or you won't come to appreciate indie rock) eventually, even though in the present they seem to reject it.

A parent's responsibility is to anticipate potential issues and adjust their expectations to reality while maintaining strong emotional ties to their children as they redefine their relationship. The bigger window of adolescence means you have more time to rebuild a strong relationship with your children. Especially for mothers, providing emotional security is the key here: if you want to regain the closeness of early childhood, accept the differences between you and your child, just as you would with anyone whom you like and respect. If you give them emotional space, they may be more willing to try to make a different kind of connection with you.

Why Does Adolescence Start Earlier and End Later?

Adolescence hasn't gotten longer (though it may feel that way to parents). It's our understanding that has changed. However, some environmental stressors have changed the way adolescents behave.

One of the clear markers of early adolescence is puberty, the time of life when a child begins to become physically and sexually mature. *Puberty* literally means to "grow hair." Your child is dealing with bodily changes they cannot control, hormonal changes that directly impact their mood, and new and changing expectations of their behavior at home and in their social sphere.

The surges of estrogen in girls and testosterone in boys that morph their bodies into their young adult forms also kick off the emotional changes and shifting brain functions associated with adolescence.

Puberty coincides with the start of the second critical window of brain development. The first is from ages zero to three, when children's brains are growing and creating new connections at an extraordinary rate. The Harvard University Center on the Developing Child released research that found that in the early years of a child's life, over 1 million new neural connections are made *per second*. The process of growth, stretching, and pruning in puberty and adolescence is not quite so dramatic but still very similar. In 1950, the average age of puberty in girls was 13.1; in 2010 it was 10.1.³ As I write this, many girls are starting puberty at age nine. Theories about why this is occurring include the increase in body fat in young girls, better nutrition and available calories, and the increase in esterothormone mimickers such as soy products.^{4, 5}

Boys are also beginning to show signs of puberty earlier. It was once thought that boys began the process at eleven and a

half; now, boys as young as nine are showing signs, like increased testicle size.⁶ Again, body weight and nutrition may be among the causes. Other endocrine disruptors such as BPA and plastics, artificial light, and hormones in meats, dairy, and soy products may also be to blame.⁵

Environment, stress, and culture may also play a role. The easy availability of adult content and sexuality through all forms of media models behavior to kids that's only appropriate for adults. More thirteen- and fourteen-year-olds are experimenting with adult behaviors like drinking, smoking or vaping, and sex.⁷

On the other hand, our new understanding of brain development has lengthened the life stage we call adolescence. While an eighteen- or nineteen-year-old is more mature physically and emotionally than a thirteen-year-old, we know that the brain of an older adolescent isn't fully developed until around age twenty-five.¹ And many young adults aren't emotionally mature, if what I see in my practice is an indication.

Peter and Carl had jobs that demanded much of their time and took them away from home often. They were fortunate to have a caregiver and housekeeper who lived with the family until both their sons, Jake and Carey, graduated from high school. The boys both went to the same college; Carey, twenty, was a junior, and Jake, twenty-three, had graduated and was living at home.

Jake often joked that he planned to move in with his parents permanently and let them take care of him. That was uncomfortably close to the truth: though he graduated with a degree in engineering, Jake didn't have a job and seemed to have little interest in finding one; his fathers gave him spending money.

Unlike his younger brother, Jake had a hard time adjusting to being on his own at college; he didn't have many friends and would often come home for weekends. After graduation, Jake showed little interest in looking for a job or going out with friends. Once again his parents tried to motivate him, but the more they "helped" by showing him job listings or telling him he needed to get out of the house, the more resistant he became. Now, he barely left the house.

Peter and Carl were deeply concerned about their son's lack of direction and were afraid they were enabling his dependence on them. They didn't know what to do. In

our sessions, Peter and Carl told me that Jake had always been a sensitive kid, crying when his feelings were hurt and when he wasn't picked on a sports team. Their caregiver told them that he would cry himself to sleep when they were away. His dads thought he needed to "stop being a baby and toughen up," and told him that big boys don't cry.

It took a while, but Peter and Carl began to understand that Jake's behavior was, in fact, an attempt to get the support and understanding from his dads that he didn't feel he had received as a child. What he needed now was not pep talks but the presence of his parents to regain his emotional health and reconnect with his family. He also needed therapy, and his fathers agreed to pay for it.

Peter decided to take a leave of absence from his job for a month, and then to work remotely, curtailing his travel for several months afterward. He spent as much time with his son as Jake wanted, listening and talking. Jake told him how much it hurt that he hadn't been able to be the son his fathers wanted; he felt he had failed them. Peter and Carl learned to listen to Jake's worries and problems without offering solutions or trying to fix him. With his fathers' support, Jake worked at several unpaid internships and found he liked the nonprofit world, where he found a job with an organization that built low-cost housing.

Often the most academically advanced and physically and cognitively precocious teens are the most emotionally delayed. An adolescent may look older than his years and be intellectually sophisticated, but if he's emotionally immature (as is often the case) the disparity is often missed by many of the adults around him, parents and teachers alike. It's why so many young people struggle with the emotional demands of their freshman year of college, or why teenage girls may be physically and cognitively advanced but emotionally unready to deal with the complications of a sexual relationship.

The adolescent brain is also still maturing. The frontal lobes, which control executive function—decision-making and organization—are still developing.⁸ This means your adolescent child may struggle with setting priorities, organizing, and remembering what is important in terms of schoolwork, sports schedules, and other responsibilities. It is why your middle schooler forgets to give you a permission slip for a field trip, or why sophomore humor is, well, sophomore.

Early Adolescence (Ages 9 to 13)

Physical Development

Early adolescence is a time of confusing physical changes, awkwardness while adjusting to new body proportions, and the beginning of sexual maturity. Boys and girls develop a new need for privacy and modesty (at least in front of their families). They become terribly self-conscious while still needing their parents to remind them to shower and brush their teeth.

For girls, puberty comes with new sensations, both painful and pleasurable: abdominal cramps accompanying menstruation, and the stirrings of sexual desire. Hair grows under their arms and around their genitalia, and they may develop acne and body odor. Their nose may grow out of proportion to the rest of their features, and they put on fat in their breasts, hips, and thighs. This weight gain, sometimes called puppy fat, is readying the body for a growth spurt. Hormonal shifts can make adolescent girls moody. Many girls feel shame around their maturing bodies and their newfound sexual feelings and fantasies. They worry about how their peers will react to their changing shape and compare themselves to friends and classmates. The girls who suffer the most are those who go through puberty early or late because they are often seen as different by their peers and can be the objects of teasing or bullying. Girls who go through early puberty also stop growing, and their height may be a source of insecurity as they get older.

For boys, puberty is a delightful mix of hair growth under their arms and around their genitals, acne, surges of aggression due to an increase in testosterone, voice changes due to thickening of the vocal cords, and unpredictable growth spurts.

Boys' hormone shifts can make them just as moody as girls. Their hands and feet are often out of proportion to the rest of their bodies. Their penis and testicles grow, and they experience uncomfortable and sometimes uncontrollable erections and ejaculations. This lack of control over their bodies can be frustrating and embarrassing.

With increasing anxiety over bodily changes and identity decisions comes a new way to release tension: masturbation. Both boys and girls masturbate from infancy and toddlerhood to self-soothe, relieve emotional pressure, and cope with anxiety. In early adolescence, however, masturbation starts to take on an additional layer of meaning. It's a way for preteens and teens to explore their new bodies and learn about all its sensations and pleasures. This behavior is now also associated with their fantasy lives and imagining contact with sexual partners, both real and unreal. This fantasy life is also the beginning of their adult sexual development. Kids lock their doors demanding privacy to try to get to know, to make sense of, and to experiment with their new bodies. Parents often have difficulty handling their teens' physical and emotional changes.

Gender and Sexual Development

Early adolescence is a time of reworking old sexual and emotional issues from earlier in development. Children have one foot in the past and one foot in the present, which allows them to work through earlier gender and sexual identity conflicts.

Gender and sexual identity begin to take shape in early adolescence. It is the beginning of going out into the world, not just identified by gender, but by sexual preference. A child may identify as a girl, a boy, gender neutral, or gender fluid. They may identify as heterosexual, gay, bisexual, or asexual. Even

though they are developing the physical equipment and desire for sexual contact, they don't have the emotional maturity, which can be both confusing and exciting, often at the same time.

Early adolescents no longer see themselves as being little with the safeguards of having big parents as authority figures who will tell them how to behave. With their new awareness of their bodies and their physical maturation, they become aware that they can procreate and have to make certain decisions about their identity and behavior.

We begin to develop our gender and sexual identity between the ages of three and six. How we relate to others in an intimate relationship begins with the love affair between parent and child, mother and son, daughter and father. It is common to hear a little boy say, "I want to marry you, Mommy," or a little girl to say, "I am Daddy's little princess." It is through the early love triangle between a child, the object of their romantic affection, and the other parent that children first experience romantic love, frustration, rejection, guilt, and resolution through repression of these romantic feelings. Children learn they have to give up those romantic feelings for one parent because they are taken and look to the future when they can have a mature love partner of their own. If the process goes well, they go on to form romantic attachments of their own when the time is right (usually in adolescence).

Social/Emotional Development

Early adolescence is when kids begin the process of discovering how they are similar to and different from their parents. This is not only the beginning of pulling away from their parents physically to feel secure in the world on their own, but the deep psychological process of determining who

they are as individuals. This requires that kids de-idealize and disengage from their parents while they figure out what their own likes, dislikes, values, tastes, beliefs, and aspirations are rather than what they've taken from or been told by their parents.

Psychoanalysts call this process separation/individuation. It occurs for the first time in toddlerhood and then again in adolescence. Originated by psychoanalyst Margaret Mahler, it describes the process by which an infant or toddler first understands that she and her mother are separate beings and eventually discovers her own identity and desires as an individual. One of the ways this occurs is through rapprochement, when a child ventures away from her mother, then returns for physical reassurance and emotional refueling. This process helps the child build a sense of emotional security and interdependence.

For an adolescent, separating and defining their identity means spending more time away from you at school or with friends. The more time they spend away from you, the more confident they may feel about their independence—but they may also become more conflicted, uncomfortable, and even guilty about the increasing separation. Primary and middle school kids still have one foot in their childhood past and the other in the present. They rely heavily on their parents to take care of them physically, and still hear their parents' voices in their heads when they're making decisions. The back-and-forth between demanding and needing independence, but also needing a physical and secure emotional home base, sucks up a significant amount of their energy and internal resources.

Moodiness is a normal part of an adolescent's emotional development. This is the time when your young adolescent screams at you for asking them what they want for dinner and

slams the door, and then gives you a hug and says, “I love you, Mommy,” fifteen minutes later.

There is a shuffling and reshuffling of the social order that takes place during early adolescence as teens try to discover where they belong and who will have their backs rather than stab them in the back. Finding their tribe is critical to surviving adolescence. Due to hormonal shifts, adolescents are less tolerant of differences and more socially aggressive with their peers.⁹ This is when “mean girls” and classic male bullying behavior emerge.

Adolescents often exclude others to be included in a group themselves; you’re either in or you’re out. Cliques form: the popular kids, the jocks, the nerds, the goths, the artists. There’s some social experimentation as kids try on different identities. Once they join a group, they strongly identify with it, and there’s rarely movement between the groups. Social groups shift; friendships formed in primary school can fall apart.

Sarah and Kara had been best friends since they were in kindergarten, but when they got to seventh grade at their small all-girls’ private school, things changed. Kara was now part of the popular crowd, and Sarah was left behind. She had no other close friends, and she was bereft at what she saw as Kara’s betrayal. Not only did her former friend ignore her at school, but when Sarah called or texted she didn’t respond. When she wasn’t at school Sarah retreated to her room. She wouldn’t talk about her hurt to her deeply concerned parents, Alexandra and Doug, but it was clear to them that their daughter was sad and depressed.

When Alexandra and Doug explained the situation to me, I told them they needed to let their daughter grieve the loss of her friend, to be sad about and angry at her former friend. Under the circumstances, cocooning herself was normal and expected. She would need them to listen when she was ready to talk, but this wasn’t something for them to fix for their daughter. What she was going through would take days and maybe even weeks. If she continued to isolate herself for more than a month, they should call me, and we would reevaluate the situation.

With her parents’ empathy and encouragement, Sarah began to cultivate friendships with other girls in her class and found some who shared her love of *Fortnite* and Korean boy bands.

Sometimes a kid doesn't find a place in any of the social groups and can become isolated. This can be a threat to their emotional health and leave them at risk. We will talk more about these issues in Chapter 6.

Same-sex friendships still dominate kids' relationships in early adolescence, although there is an increasing awareness of and interest in the opposite sex. Some precocious early adolescent teens split off into individual romantic/sexual relationships, but they are the minority.

Cognitive Development

Early adolescence includes a process of moving from concrete or binary thinking to more nuanced, integrated, and abstract thinking. In the early childhood and primary school years, children think of things as right and wrong, good and bad, black and white. They take things quite literally: when my husband was seven, he would ask where the white planes were when his mother drove through the city of White Plains. Most children begin to understand by the age of twelve that language is nuanced and that words have deeper meanings and depth.

Early adolescents are beginning to grasp that meaning is influenced by perception, symbolism, and abstraction, and that right and wrong may be relative to one's beliefs and circumstances. They start to use metaphor in speech as they grasp that situations can be viewed from multiple perspectives. However, they still show signs of binary thinking, categorizing people and experiences as good or bad.

Middle Adolescence (Ages 14 to 18)

Physical Development

By the end of middle adolescence, teens now know where they fit in with their peers physically. Most have achieved their full height and body shape, although getting there can be a painful and disorienting experience. This is often the case for boys, whose development can be uneven and unpredictable. Boys who go through puberty late may feel embarrassed about their stature, lack of body hair, and the size of their genitals when they compare themselves to their friends. Growth spurts can be quite literally painful. By fourteen, many girls have gotten their periods and may look older and more mature than their chronological age.

Although they are taking more responsibility for their own bodies in terms of self-care, teens can still be quite dependent upon their parents to provide structure around eating, sleeping, and hygiene. It's ironic that the girl who spends an hour in front of the mirror with a curling iron needs to be nagged to brush her teeth, or the boy who was dragged kicking and screaming to take a bath when he was ten now spends an hour in the shower.

These middle teens put more emphasis on their physical appearance and are more conscious of their imperfections. This is the time when having a bad hair day or a pimple on your face can feel like the end of the world. This is also the time that many teenage girls and boys develop eating disorders as they begin to feel self-conscious about their bodies and compare themselves to others, contemporaries as well as celebrities. The carefully posed posts of social media influencers and selfies altered with Instagram filters depict artfully staged moments of perfection against which these teens measure themselves.

Gender and Sexual Development

Middle adolescence is the time many teens declare their gender or sexual identity. They commit to these descriptions of

their identity.

The one-way crushes of early adolescence continue into middle adolescence, and teens may still focus on fantasy relationships or infatuations. These are “safe” romantic and sexual relationships because they don’t have to deal with messy or unreciprocated emotions or physical contact. Middle adolescents are also beginning to explore reciprocal or two-way relationships and experience emotional connection. Both boys and girls are exploring sexual feelings, sensations, and desires toward other people through masturbation and fantasy. A fourteen-year-old girl might plaster her room with posters of her favorite singer (confession: I had posters of Donny Osmond and David Cassidy) and fantasize about him (or her) while masturbating. When she’s seventeen, she’s just as likely to fantasize about someone in her chemistry class.

Although children masturbate from a very young age, they don’t have the ability to orgasm until adolescence.¹⁰ Once they discover the pleasures of sexual satisfaction, girls and boys will explore these sensations alone (as any parent of a teenage boy who has found a wastebasket full of wadded-up tissues knows), as well as experiment with others. The more comfortable you are with your child becoming a sexual being, the less self-conscious and anxious they will be about their bodies and sexuality, and the more likely they are to talk to you about their feelings and concerns. This is especially important when (not if) they become sexually active.

Social/Emotional Development

Middle adolescence marks a visible shift away from teens relying on the approval and support of their family to looking for the approval and support of their friends. Though they may be consciously questioning or rejecting the culture and values

of their family in favor of that of their peers, they take their family's internal guidance with them. If early adolescence finds kids pushing their boat away from the safety and security of their family, in middle adolescence they find themselves in the middle of the lake, unsure in which direction they're going to paddle.

This push into the unknown waters of independence is exciting but comes with a heavy dose of anxiety. It also comes with the need to deal with the loss of childhood and the feeling of isolation from their parents. Once teens mourn these losses of childhood, they can focus on the present.

Teens are still practicing taking care of themselves physically and emotionally, and they still need and rely upon their parents to take care of them, including their bodies. It is an important developmental milestone when teens learn to regulate themselves and take care to eat well, sleep enough, dress properly, and organize their stuff, whether it's having their basketball uniform washed for the game the next day or making sure they are prepared for their test on Friday.

Part of this struggle is emotional, meaning they still need to be dependent on you to care for them, even if they don't admit it. If there is no healthy dinner for them when they come home from school, they are more likely to eat Twinkies rather than make themselves a turkey sandwich or heat up leftovers.

Encouraging independence in action is different than demanding that our children be emotionally independent from us. We shouldn't confuse emotional independence with competence in life skills. Your fourteen-year-old can be responsible for remembering her homework, and if she doesn't, you can empathize with her disappointment without shaming her. You can help her figure out a better system for keeping track of her assignments and suggest ways she could approach

her teacher for extra credit to bring up her grade. That's not the same as doing the assignment for her, packing her backpack, and going to the teacher yourself if she forgets to hand it in.

Middle adolescence can be a time when even well-adjusted teens experience significant depression and anxiety.¹¹ Teens are focused on and live their lives in the moment, which is both good and bad. If your child is happy socially and doing well in school, it can feel like the best time of their lives. But if they are unhappy or not accepted by their peers, they may feel that they will be stuck in their unhappiness forever. This is why teens can feel particularly alone and hopeless.

Middle adolescence is a time of idealizing people and movements. Teens are now loudly and passionately declaring their philosophical, religious, and political beliefs. They get involved with political campaigns, philosophical movements, and religious sects. This is true across history, as with Joan of Arc (who was seventeen when she took up the sword for France against the English) and environmental activist Greta Thunberg, who addressed the United Nations Climate Change Conference at fifteen. These beliefs, which mental health professionals and sociologists refer to as a person's sociocultural identity development, are part of the process of individuation. It is one thing to separate yourself physically from your parents and another thing entirely to know what to take of what they gave you and what to leave behind. This is both exciting and terrifying.

Teen social life involves moving from group activities to pairing off. Kissing and holding hands gives way to more intimate sexual exploration. Kids are having intercourse at a younger age. According to the 2017 CDC Youth Risk Behavior Survey, 39.5 percent of high school students said they had had

sexual intercourse. Ten percent said they had had sex with four or more partners. Of the 30 percent who had sex in the three months prior, 46 percent of those had not used a condom. Kids who were sure of their sexual identity, whether they were heterosexual, gay, lesbian, or bisexual, had more sex than kids who weren't sure of their sexual identity.

Parents must not make assumptions about what their teens know about sex and when they become sexually active. The parents I work with are often shocked to learn how young kids are having oral sex, genital intercourse, and even anal intercourse. This is only one of the reasons that parents need to have conversations about sex and responsibility much earlier than they may want to. I discuss this topic at length in Chapter 4.

Pack behavior doesn't go away, but single-sex group activity gives way to coed activities. Couples form groups together, and parties are not just the guys sitting around watching football or the girls hanging out and having sleepovers. Mixed-gender parties bring up issues including social acceptance or rejection, social inclusion or exclusion, popularity or fears of isolation.

Nature hates a vacuum, and teens seek out other adults to fill the vacuum left in their emotional life when they (necessarily) separate from their parents. Coaches, teachers, musical performers, sports figures, and political leaders become their new parental models, and they look to them for guidance and advice. At the same time, teens still feel the tug toward their parents and the safety of home. They may react to this unconscious longing as a threat to their emerging independence and may lash out at their parents for no obvious reason. Parents may be able to get through this period by being aware that their kids' hostile behavior and responses to seemingly innocuous questions or requests may not be a

reaction to them, but a reaction to their kid's own internal conflict.

Cognitive Development

Even though their consciousness is firmly planted in the present, teens are developing complex thought processes. They can look at a situation from multiple points of view and are no longer limited to concrete thinking. The ability to engage in abstract thinking allows them to look beyond the boundaries of home and middle or high school to a larger world of emotional and intellectual possibilities. They're beginning to ponder more existential questions: Is there a God? What am I supposed to do with my life? How can I make the world a better place?

Being self-centered is one of the necessary developmental tasks of adolescence and requires deep introspection and self-absorption. Like a caterpillar that cocoons to emerge as a butterfly, adolescents need to retreat into themselves to discover who they are. Only through this process can they emerge being able to not only think about themselves but others as well. This means that for a short (or sometimes a not-so-short) time, they may seem to be insensitive to the needs and feelings of others.

It doesn't help that memory and judgment are not yet entirely developed during adolescence.^{[11](#)} When you tell your fifteen-year-old to clean up her room and she doesn't, she's not necessarily rejecting your authority; she may really not remember. Your son may tell you he's sure he told you he needed a yellow shirt for the band concert when you know he didn't. Why? Adolescents' memory issues are part of the extensive pruning and shifting in their brains. They also struggle to remember which conversations they have had with you in person and which ones they had with you in their heads.

In terms of judgment, we all know that they don't always make the best decisions.

This is all normal.

I'm not saying that rudeness or bad behavior is acceptable, but you should understand that your child's brain is not yet "fully cooked," even if they look like an adult. This period can be frustrating and sometimes infuriating, but if you can keep your cool—at least most of the time—and model communication skills, empathy, and sensitivity for them, your child will come out on the other side with a better sense of themselves and the ability to relate to and be part of the world of interpersonal relationships.

Where a younger child may react to a bad grade with an emphatic "That's not fair! My teacher sucks!," middle adolescents can recognize that a not-so-good grade reflects that they may not have studied hard enough for a test or didn't put enough effort into a project.

In addition, adolescents are becoming comfortable with intellectual ambiguity and exhibit mental agility and flexibility. They can develop hypotheses, test them out, and consider different perspectives politically, philosophically, aesthetically, and spiritually. They love a good argument; if you've ever sat through a high school debate or discussed a subject like climate change with a teen, you'll know what I'm talking about. I've had parents tell me that they feel like they're watching a Ping-Pong match as their teens experiment with different points of view while developing their own independent lens.

Late Adolescence (Ages 19 to 25)

Physical Development

Now kids are unmistakably young men and women. The most dramatic and uncomfortable physical changes of adolescence are behind them, though girls may continue to lose more body fat, and boys get more muscular. Boys may also grow more facial and body hair. There's more comfort and acceptance of their bodies, and their concerns begin to shift from immediate concerns about their physical selves to what place they will have in the adult world.

Gender and Sexual Development

If your child experimented with gender and sexual orientation in mid-adolescence, by late adolescence they have probably confirmed for themselves who they desire and how they want to identify themselves.

Late adolescents go from being more self-centered to having loving sexual relationships with those who desire them also. There is often a deepening of reciprocal love relationships and the beginning of real intimacy with a love partner. This emphasis on sexual as well as emotional intimacy leads to the commitments that older adolescents make in adulthood.

Sometimes these first serious relationships have a passionate, joined-at-the-hip quality that isn't sustainable. Healthy intimate relationships are interdependent: there's a strong emotional bond that exists; at the same time partners respect each other's individuality. Finding the balance of connection without merging and intimacy with boundaries is a complicated balancing act, which is why many early relationships don't work out.

Social-Emotional Development

The most important goal and milestone of late adolescence and young adulthood is finding one's place in the adult world.

At eighteen, these young people are now adults in the eyes of the world and of the law; they have control over their privacy and medical decisions, they can drive, vote, marry without anyone's permission, and drink (at the age of twenty-one). For secure and emotionally healthy young adults, it is an exciting and anxious time. For emotionally fragile or insecure and anxious young men and women, this is when they are most likely to break down.

At this stage of development, the goals, hopes, and dreams of adulthood begin to take shape in the context of a realistic picture of a person's actual strengths and limitations. This reckoning with reality can stir up painful feelings in many late adolescents—and a sense of relief in others. It helps to have a sense of humor. My younger son told me, "I've come to terms with the fact that I have a better chance of managing a basketball team than being a professional basketball player."

In emotionally healthy kids, the self-consciousness of earlier adolescence (I have a pimple and that's all anyone sees when they look at me; I am the pimple) gives way to a kinder, more forgiving view of themselves. In some kids, however, that internal voice calcifies into a harsh, critical voice that becomes the foundation for perfectionism, anxiety, and depression. This is usually a combination of both nature—if your kid was the one who beat themselves up for the smallest mistake in grade school, they're more likely to continue to do so—and nurture, the pressure of external expectations. It is common for the internal voices we hear in our head when we make a mistake to be an exaggeration of the voices of our parents. We can soften their harsh internal critic with realistic expectations based on their personality and temperament, and *authentic* admiration of their strengths and accomplishments.

Knowing how to practice self-care is not a given, just as resilience is not a given. For many young adults, the sudden weight of the responsibility that comes from being responsible for themselves and their actions and behavior is too much to handle. This is when I see young people break down. If this is your child, this may come as a surprise to you, especially if they seemed self-sufficient or were high achievers socially or academically. To be out in the world “alone” without the support and safety of being cared for by others can feel terrifying if kids have not learned how to take care of themselves or take responsibility for their mistakes.

Most young people are spending less time with their parents, even if they’re living in the same home. Thoughts turn to the future, leaving home, taking on adult responsibilities, and the freedom to be their own authority. They are motivated by their own desires rather than pleasing their parents. This can create tension in that relationship when parents face the reality that their children no longer need or rely on them completely. “You mean my kids don’t need me anymore?” parents will often ask me. I tell them that they do need you to be their sounding board and cheering section. It should not matter if the choices they make are different from the ones you would make for them. I suggest parents see this time as an opportunity to redefine and refresh their relationship.

Cognitive Development

A major difference in these years is the ability of late adolescents to think deeply and be reflective about the past, present, and future. In late adolescence and early adulthood the door opens to the ability to integrate past, present, and forward thinking. Considering a possible future can be exhilarating to a healthy young person while an uncertain outcome and fear of

failure can be frightening to a less emotionally secure or less resilient adolescent.

Older adolescents have decided which parts of their parents' beliefs and ideas they will adopt as part of their identity and which they will leave behind. They're less threatened by the idea of family closeness and may be more comfortable spending time with their family.

Important life decisions like which job or career to choose, who they can love, or where to live are based more on realistic expectations and actual opportunities than on fantasies. Late adolescents understand that if they're making an entry-level salary they'll need to have roommates if they want to move out of their parents' house.

In addition, their ability increases to think abstractly and symbolically, and also to grasp more challenging concepts that are not binary or black-and-white. These young women and men understand nuance; the idealization of middle adolescence has given way to realism and being able to see and appreciate that people are imperfect, which is good enough. They are less dogmatic and are willing to accept that, for example, a political candidate may not be their perfect choice, yet still be the best choice. They have increasing intellectual objectivity and can hold in their mind multiple perspectives without feeling defensive or threatened.

What I've laid out in these pages are the stages of development you want to see as your kids grow and mature. What happens when this process doesn't unfold as expected, and what can you do? That's what I'm here to help you with next.

CHAPTER 3

UNDERSTANDING THE ADOLESCENT BRAIN

Understanding why your child does what they do starts with understanding how their physical brain works. During adolescence, your child's behavior will often seem erratic and unpredictable, and sometimes confounding. Forewarned is forearmed: reason often gives way to reaction, and parents would be wise to expect the unexpected. Not only is it a time of brain growth, but also of pruning and reorganizing as the connections between the reward centers and parts of the brain that regulate emotions are being formed. These parts of the brain develop at different rates.¹ This is why adolescents' emotional highs are higher and lows are lower, and they are in a category unto themselves in terms of impulsivity, risk taking, poor judgment, erratic emotional behavior, and moodiness. It is also why there is an increase in mental disorders in adolescents.²

The brain is a plastic organ—that is, it grows or shrinks in response to the environment.³ As their brain grows in infancy and toddlerhood, children are laying the foundation for emotional health and resilience to stress in late childhood and adolescence, while in adolescence they're laying the foundation for their emotional health as adults.

From the time your child was born until the age of three, their brain was growing at an extraordinary rate, creating brain cells (neurogenesis) and connections (synapses) between them (synaptogenesis).⁴ A healthy child creates *too many* neurons and synapses. The same thing happens during adolescence.⁵ Scientists call these times critical periods of brain development, when the organ is highly sensitive to its environment and where a young child's brain is molded by interactions with their parents and earliest caregivers.^{6, 7} By three years of age, 85 percent of a person's brain mass (the number of neurons) is almost developed, and by the time they're twelve or thirteen their brain has finished growing in size.⁸ These periods of rapid growth are accompanied by an equally intense burst of "pruning": unneeded or unused neurons and synapses die off. Pruning is necessary: it's the process of cutting back the weak branches so that healthy ones may grow.³ If you're not a gardener, think of it like having a full DVR; you can't add more shows until you remove the ones you don't watch anymore.

Brain Architecture 101

To understand your adolescent's development and behavior, it helps to be familiar with the parts of the brain that control their social-emotional or right-brain development:

- The prefrontal cortex (PFC), which governs emotional regulation, judgment, and executive function
- The ventral striatum, which governs the reward system
- The limbic system (amygdala and hippocampus), which controls threat sensing and stress regulation

What Do Hormones Have to Do with It?

Puberty, the time when adolescents become sexually mature (at least physically), is a long process of hormonal and neural growth that begins sometime between the ages of nine and sixteen. When puberty begins for each individual depends on genes and environmental factors such as diet and body fat ratio, and is also affected by stress.⁹

During puberty, the brain sends hormones to the reproductive organs, which begin to produce hormones that we associate with sex: estrogen and testosterone. These hormones in turn affect behavior. Fluctuations in hormones affect emotions and cognition. In both boys and girls these intensify mating behavior.¹⁰ From the perspective of evolution, it's an effective way to keep the human race going. There are cultures where people marry or partner and have children as teens or young adults; they have the support of their extended families and community. Even then, adolescent love can test social boundaries. Remember *Romeo and Juliet*? In most contemporary societies, however, it means that teens want to have sex before they're emotionally ready.

In boys, the increase of testosterone activates the reward (ventral striatum) and threat-sensing centers of the brain (amygdala), which leads to more risky behavior before the emotional control and regulation part of the brain (PFC) is developed enough to put on the brakes.¹¹ Boys are more motivated by rewards than girls and have a harder time controlling their reactions to rewards due to testosterone. The classic movie *Rebel Without a Cause* captures this dynamic perfectly.

Girls are no picnic either. They are producing more estrogen and have a higher activation of brain regions associated with

social processing and information, which leads to more compulsive and self-conscious behavior.^{[11](#)}

Although we know hormones get the ball rolling and help explain a lot of the chaos of adolescents' emotions and their behavior, it is the asymmetrical development of the motivational/reward and regulatory systems of the brain that is really responsible. During adolescence the limbic system becomes very active and runs roughshod over the emotional control center of the brain, the PFC.^{[1](#)}

Hormones are also deeply involved with adolescent sleep patterns. According to the 2014 Youth Risk Surveillance Survey, 90 percent of U.S. adolescents are chronically sleep deprived and suffer for it. Early school start times are partly to blame. Teens have a condition called “sleep wake phase delay.”^{[12](#)} When I say “condition,” I don’t mean that it’s abnormal or unusual. Nature intended teens to go to sleep later and wake later. They prefer later bedtimes and wake times—up to two hours later than younger children—because in adolescents, melatonin is released later in the night, which makes falling asleep earlier difficult.^{[13](#)} They also experience less “sleep pressure,” the pressure or desire to fall asleep. These factors mean teens tend to stay up later; when they have to get up early for school or extracurricular activities, they wind up feeling sleepy and lethargic during the day. Sleeping longer hours on the weekend to “make up” for lost hours doesn’t work.

As frustrating as it may be for you when you’re trying to get your kid out the door on time, we can’t control when school starts. We *can* offer empathy and understanding toward the very real struggle to reconcile biology with outside demands. Instead of adding to our kids’ anxiety, we can help them make

adjustments to their sleep habits, including modifying their use of phones and other tech.

While it's normal for your teen or young adult to stay up until 1:00 AM and have trouble getting out of bed in the morning, chronic insomnia and other sleep disturbances are not normal. If your child's sleep issues persist for more than two weeks, speak with their doctor.

Emotional Regulation and the Prefrontal Cortex

The prefrontal cortex (PFC) takes up 25 percent of the human brain.¹⁴ It is responsible for emotional regulation, social orientation, long-term planning, executive function, and impulse control. It is the last part of the brain to mature and is not fully developed until a person is in their mid- to late twenties. The PFC is the part of the brain most shaped by experience and the environment.¹

The PFC is the central hub of traffic control that guides neural activity. It is responsible for what scientists call *executive functioning*, the processes involved in impulse control, organizing information and the ability to decide what is and is not important, decision making and judgment, and working memory, which allows us to recall things from moment to moment. As we mature physically, so does the PFC, and our ability to reason, problem solve, plan for the future, make decisions, focus our attention, use language, grasp abstractions, and self-regulate emotionally and physically matures too.¹

The PFC has a unique relationship to the limbic system (see [page 64](#)). The limbic system is sometimes called our “lizard brain”; it's the most primitive part of the brain and develops first. The limbic system controls our stress reactions and, when we think we're threatened or in danger, creates a fight-or-flight

response. These two parts of the brain are the reason we may react one way in a stressful situation and regret those actions later. As adolescence starts, your child's brain is marinating in hormones and the prefrontal cortex is struggling to keep up with the limbic system, which is fully online.

Intense emotion can interfere with learning.¹⁵ This applies to both academics and life lessons. A middle school history teacher (and parent) once told me that between sixth and eighth grades she sometimes felt like her main job was to contain the kids in her class and keep them from hurting themselves and one another. By the time they hit ninth grade, they were more capable of settling into class and actually learning. When the PFC is fully developed, it helps moderate our immediate visceral responses and can suppress distractions.¹ I think of it as adding ballast to a boat; the PFC helps steady us in an emotional storm.

The PFC is involved in a critical social skill called *mentalizing*, which allows us to have close and intimate relationships. This complex skill gives individuals the ability to assign mental states, intentions, and desires, and to recognize the meaning in words implied by tone and emotional nuance, such as in sarcasm. This skill gives humans the ability to understand the mental state of ourselves and others, and helps us understand that others have beliefs, desires, intentions, and perspectives separate from our own. The development of mentalizing is critical for empathy, as well as interpersonal connection. It requires good executive functioning, working memory, and impulse control, which is why many adolescents seem selfish or self-centered.¹⁶

Mentalizing has some instinctual foundation from early childhood. We are born with an innate capacity to connect with

others; however, it is a learned behavior and has to be reinforced. Babies have mirror neurons that help them copy or reflect the expressions of their mothers or primary caregiver.¹⁷ If a mother or caregiver doesn't or can't reciprocate their child's expressions, these neurons don't develop, and the connections aren't made.¹⁸ You see an extreme result of this in children who have been neglected or abused. A classic example are children who have been adopted from Romanian orphanages.¹⁹ A child whose autism has roots in utero and is the result of abnormalities of brain structure or function may not be able to learn to mentalize and may lack empathy; they have great difficulty reading social cues or detecting nuances in tone or body language.²⁰ If they cannot recognize or name their own feelings, they can't imagine that others might feel the same way.

In learning to empathize with another person, we must first call upon our *own* feelings and reactions and then project them on to others. This requires that we are aware of what we are feeling and can imagine that another person might feel the same way, even if our circumstances are very different. Teenagers and young adults struggle to hold both their own perspective and feelings as well as those of another at the same time. It's why they may not be able to speak up when a schoolmate is being bullied; it's too scary and threatening to imagine being in the same position themselves. As we evolve into adulthood we can feel for others without having to rely on a similar experience.

Mentalizing and developing empathy require modeling, which means observing and following an example. Positive social behaviors like cooperation, empathy, volunteering, and sharing are the result of a combination of environment and brain development. When parents recognize the feelings of

their young child and reflect them or can imagine how their child might be feeling, the parents are modeling what it is to mentalize. Parents can use the same techniques with their adolescents to encourage empathy.

The paradox is that while adolescents may not always be good at feeling empathy with individuals (especially their parents), with their limbic system in overdrive they can be passionate about embracing social causes because they are looking for something bigger than themselves to belong to and believe in. While the PFC strains to catch up with the limbic system, the intensity of their feelings means they cannot always distinguish what they can and cannot do.¹ Egocentric as they may be, late adolescents can sometimes feel for others very intensely, and combined with an impulsive desire for action and inexhaustible energy, they may believe that they can heal the world. Community service projects are a way to take advantage of these feelings and develop empathy. A friend's son went on a service trip to Puerto Rico when he was fourteen. At home he was often uncommunicative and sometimes sullen. When he returned his parents told me he compared his comfortable life to the community he helped repair, and they saw a real, if subtle, change in his behavior.

As adolescents continue to develop, their prefrontal cortex, ventral striatum, and limbic system work together, making possible empathy and the ability to hear, understand, and feel for multiple perspectives.²¹

Risk, Reward, and the Ventral Striatum

The ventral striatum (VS) is the motivational/reward and regulatory center of the brain. It is part of another neural network that involves the PFC, the amygdala, and the

hippocampus. These parts of the brain work together to predict, evaluate, and respond to a physical or emotional reward. In adolescents the VS develops and becomes intensely active before the PFC has had time to catch up and regulate it. It's one of the reasons adolescents engage in rebellious, sensation-seeking, and risky behavior—experimenting with drugs and alcohol, vaping, high-risk sex, petty and violent crime, and reckless driving.^{[22](#)}

The reward circuit is rich in the neurotransmitter dopamine, a chemical signal released by neurons that is involved in detecting, responding to, and learning from rewards.^{[21](#)} There is a neurobiological reason for the heightened reward-seeking and risk-taking behavior. There's not more dopamine in the adolescent brain than an adult's brain; it's the pattern of release that's different. During puberty there are not just surges in dopamine in response to stimulation, there is an overproduction of dopamine receptors. If a little of anything—sugar, sex, alcohol, caffeine, money, popularity, an adrenaline rush—feels good, a lot feels much, much better.^{[23](#)} For this reason, teens and young adults may seem to go overboard—too much sugar, too attached to their likes on social media, too obsessed with video games, too in love with fast cars and motorcycles.

If you put an adult in a brain scanner and give them a small reward, say a square of chocolate, there will be mild activation of the dopamine circuit. Give them a little more chocolate and there will be a medium amount of activity. Give them a really big chunk and there will be a lot of activation. Now put a teenager in the scanner. Give them a small piece of chocolate and you'll see a small reaction; then a medium-size piece of chocolate and watch a medium reaction. But give them that

same big piece you gave the adult, and their brains flood with a much greater amount of dopamine.

Binges are actually a normal part of adolescent behavior. It's not uncommon for a teen to eat a whole bag of potato chips at one sitting or have trouble putting down their phone or video game controller. There's a pruning of dopamine receptors as kids move toward adulthood.²³ When this happens, they don't need constant stimulation to be satisfied. If you're worried that your child doesn't seem to be able to put down their phone or video controller now, it doesn't mean they'll be addicted to that behavior for the rest of their life.

The problem arises when a child has suffered a trauma—the death of a parent or loved one, chronic bullying, divorce, poverty, neglect or abuse, serious illness—or deep loss like moving, changing schools, breaking up with a friend or boy/girlfriend, or disappointments like not making the traveling sports team or the school play. These psychological wounds can derail normal development, as can underlying mental health disorders like anxiety and depression.²⁴ When this happens the binge behavior that a child would ordinarily grow out of can persist. For example, binge/purge eating disorders, which often begin in adolescence, are an attempt to use food as a drug and take advantage of the dopamine surge that results from eating a lot of sugar.²⁵ It's a short-term strategy to cope with a bigger problem and has serious long-term issues, as these kids (usually girls) become slaves to the dopamine rush. We look at these issues more closely in Chapter 7.

You must wonder what nature intended when adolescents were given this high-risk, high-reward sensitivity. There are, in fact, some advantages. Due to these brain changes, adolescents have a higher tolerance for the unknown than adults, which

allows them to take advantage of learning opportunities and novelty, makes it easier to separate from their parents, and helps them to innovate, create, and procreate.²⁶ Moderate risk-takers in adolescence do better in life and socially.²⁷ These young people are innovators and experimenters in ways that become increasingly difficult as the PFC exerts more influence. Think about Bill Gates dropping out of Harvard to start Microsoft.

High-risk behavior, however, can have serious consequences. Of the approximately 13,000 adolescent deaths in the United States each year, the leading causes are preventable: motor vehicle crashes, unintentional injuries, homicide, and suicide, as stated by the National Center for Health Statistics. Decisions made during adolescence also set the stage for later adult behaviors: according to the CDC, 90 percent of adult smokers become addicted to nicotine by age eighteen and an estimated 5 million people under the age of eighteen who are alive today will die prematurely from smoking-related illness. The good news is that if people don't start in adolescence, they are unlikely to do so later on.

Adolescents are bad at assessing risk in a particular way, as shown by a study conducted at the University College of London; they cannot process negative consequences, only positive ones. Anyone who's lectured their teenager about the risks of drunk driving and been met with a blank stare or shrug knows what I'm talking about. Adults have the same desire to do stupid things, but our fully matured PFC prevents us, mostly, from doing so.

In addition, friends and peer group support activate the ventral striatum and enhance the behavioral responses to rewards. Functional magnetic resonance imaging (fMRI) looks

at the brain while it's responding to stimuli. Using fMRI technology, Temple University researchers observed high school students, college students, and adults playing risky video games. College students and adults took the same kind of risks whether they were alone or being watched by their peers. High school students, on the other hand, took more and greater risks with peers watching.

The fact that adolescents respond strongly to positive consequences (rewards) gives parents a way to help manage their behavior. (I won't say manipulate or bribe. You may call it that, and that's fine.) A study headed by Monique Ernst found that when adolescents were provided with a monetary reward, they did better in experiments that required them to control their behavior and focus. In this experiment, the adolescent's VS was activated in the service of learning. On the home front, money and sugar in the form of snacks and baked goods are good motivators. Some people say it's not good to pay for good grades; I disagree. The brain science makes a good argument for incentivizing rather than punishing teens. A 2016 experiment in which teens were asked to remember images that flashed on a computer screen showed higher connectivity between the hippocampus, which is responsible for learning and memory, and the VS when teens were given positive reinforcement and rewards.

The Limbic System: The Amygdala and Hippocampus

The limbic system is made up of the brain structures and circuits that are involved in regulating stress. The parts that are particularly important to understanding your adolescent are the amygdala and the hippocampus.

The amygdala is a small, almond-shaped brain structure that is involved in regulating our emotions and our fight-or-flight response to threats. It may also be involved in sex drive and helps us to read emotions and mood in others. You can think of it as part of the social part of the brain, along with the PFC, which helps decode facial expressions and regulates the amygdala's response. I explain it to clients this way: I was sitting in my living room listening to a classical violin concerto. My son turned up his favorite metal band album, drowning out the concerto. Think of the amygdala as a metal band; it overpowers the classical music, the PFC, even if both are played at the same volume. Once the PFC matures, it can turn down the volume of the amygdala, modulating emotional responses.

The amygdala responds to emotional facial cues, and most strongly to a fearful or angry face. This is part of our survival instinct, and the response is stronger in infancy and early childhood (zero to three years old), and again in adolescence.²⁸
²⁹ Things like face processing, understanding others' mental states, emotional processing, and interpersonal interactions are front and center in adolescence.

An infant or toddler relies on her parents and caregivers for survival; if they're angry or upset with her, it's in her best interest to please them. It's why babies become distressed if they see an angry expression and why they're drawn to smiling faces. Like Picasso in his Cubist period, babies fixate on specific parts of the face, such as the mother's eyes or her hair, which they recognize as different from anyone else's eyes or hair. After age three and until they reach adolescence, children learn to see a face as a whole.³⁰ Freud called this calmer period between the ages of five and nine the *latency period*; now we have the neuroscience to understand why this is a time of relief between

the frenzied brain growth and activity of early childhood and adolescence. Once puberty gears up, kids see faces as parts again. This is why when your teen says she cannot go to school because she has a big pimple, or complains about the size of her nose, it really is all she can see. And she's right that her friends and schoolmates may focus on it too.

Adolescents have transferred their social focus from their family to friends, schoolmates, and other adults; what others think of them is more important than their parents' opinion. They rely on social cognition or "the ability to use signals by members of the same species to navigate the world."³¹ In adolescents the amygdala reacts to the fear of social rejection, not physical harm; social sensitivity or self-consciousness increases dramatically. These kids feel under incredible social scrutiny. Girls are more self-conscious than boys due to greater activation of the limbic system. They become more sensitive to social slights and being excluded.³²

Teenage angst and emotional pain are real. In a 2000 study, teens and adults played a video game with two peers. The two other teens or adults were instructed to act as though the test subjects were being ostracized. Brain images showed that this behavior initially activated the amygdala in adults. Shortly after, the PFC activated, calming the activity of the amygdala and moderating painful emotions. In teens the amygdala lit up, but the PFC remained silent and did not help regulate the anxiety and painful emotions.

The hippocampus is the part of the brain where our short-term and working memory live. Short-term memory is remembering where you put your house key when you came home last night. It is a component of working memory, which is the temporary storage and processing of new and previously

learned information.³³ A healthy hippocampus is critical for learning, attention, and focus, things that are critical to remembering how to drive a car or study for an exam.

Working memory allows us to recall things from moment to moment. It is in the process of being developed during adolescence.³⁴ This is the biological reason why when you ask your fourteen-year-old to take out the garbage, they say yes, and then they tell you they forgot, or don't remember that you asked. Or why your daughter asks where her jeans are when you told her they're in the laundry. They're telling the truth; their short-term and working memory don't work efficiently yet. Immature working memory also affects judgment. While the definition of insanity may be doing the same thing (like breaking curfew) and expecting a different outcome (you won't be angry when they do), your teen isn't crazy; it's just their undeveloped working memory.

As frustrating as it may be for you, repeating requests and reminders is as important in adolescence as it was when your child was a toddler. Get used to repeating yourself. The younger the adolescent, the more difficulty they have ignoring distracting information that interferes with working memory. As they get older and the PFC again controls the regulation of emotion necessary for good working memory, their ability to recall, to be precise, and to control distraction improves. Another thing that improves working memory? Movement. Exercise has been shown to improve performance on memory tests.³⁵ Kids who play sports often do better in school. They may have less time to study but their brains work more efficiently. They don't have to lift weights or be a track star; any kind of exercise makes a difference.

Stress and the Adolescent Brain

Stress is a part of life, and part of growing up is learning to deal with stress—whether it’s worrying about an upcoming history exam, figuring out how to pay for college, or going on an important job interview. Stress activates the fight-or-flight circuits of the limbic system. The amygdala sends signals that ultimately tell the adrenal glands to release hormones like adrenaline (epinephrine) and cortisol into the bloodstream. Adrenaline causes the heart to beat faster, and the rate of breathing increases to take in more oxygen, which is sent to the brain, increasing alertness. Cortisol floods nutrients like blood sugar (glucose) and fats into the bloodstream, supplying energy. It also helps shut off the stress response after the threat is gone. The amygdala also stimulates the production of dopamine, which can increase focus and the cognitive processes necessary to cope with stress. When the threat is over, hormone levels, heart rate, and breathing return to normal.³⁶

Some stress is good and can help motivate us to change and action—making a study plan for the history test, starting a college fund, or preparing for that job interview. When stress is overwhelming, as when we experience a trauma, or is constant, as in a bullying situation, poverty, or family dysfunction, it can create a negative feedback loop. It’s as if the amygdala gets stuck in the “on” position, with the hippocampus failing to shut down the production of the fight-or-flight hormones, like cortisol. As a result, those hormones remain in the body, and an adolescent becomes even more anxious and defensive, maybe even aggressive, even when the source of the stress is gone—the test is over, or they got the job. Too much dopamine pumped out by the amygdala may also be responsible for problems with attention as well as learning and problem solving.³⁶ This

constant state of hypervigilance leads to physical changes in the brain: nerve cells don't regenerate, and the hippocampus and amygdala shrink.³⁷

Adults suffering from PTSD have shrunken amygdalae.³⁸ It's like a lightbulb that gets too much current and blows out. This also interferes with the ability of the brain to hold on to new information.

Learning to handle stress is one of the most important skills you can teach your child. We talk about this more in Chapters 5 and 6.

Have faith that the moods, impulsiveness, and often erratic behavior of your teen or young adult, while usually part of normal brain development, are not permanent states of affairs and will pass, even if not as quickly as you'd like. Try to remember what it was like for you—the confusing feelings, the unexpected moods and urges. They're not deliberately trying to defy or upset you—most of the time—and even when they seem to enjoy provoking you, it's part of the necessary and unavoidable process of a child's brain becoming that of an independent adult. If you can stay calm and empathetic, you'll both negotiate the sometimes harsh landscape of adolescence and come out with a stronger relationship on the other side.

CHAPTER 4

GENDER AND SEXUAL IDENTITY

It is hard for parents to think of their children as sexual beings, but they are. One day they were little and innocent and coming to you for snuggles and kisses, and it feels like the next day they are young women and men, curious and eager to learn about sex from and with their peers.

Sex, sexuality, and gender identity can be uncomfortable subjects for parents and kids to navigate. Many parents want to delay discussing these subjects with their children. I wouldn't wait. Even elementary school children are being exposed to strong and consistent messages about sex, gender, and sexuality from every kind of media. It's impossible to shield your child from information or images they may not understand; even if you have set firm limits on what they can read, listen to, and view at home, you can't control what they're exposed to outside or hear from their friends and schoolmates. Discussions that earlier generations of parents would have had when children were thirteen and fourteen (or not at all) need to happen by the time children are nine or sometimes younger.

There's no doubt that the world has changed dramatically, even within the last generation, and with it attitudes about sex, sexual identity, and gender. Signs of puberty usually appear around eleven or twelve years of age for both boys and girls but may appear as early as eight in girls and nine in boys.¹ Our kids are exposed to a more sexualized environment than earlier

generations and often become sexually active before a parent is aware that it's happening.

How we look at the broad spectrum of sexuality, sexual identity, and gender has changed from a narrow binary division to a more inclusive view. For example, homosexuality, once believed to be a mental illness, has been removed from the *DSM-5*. The public conversation about who we are as sexual beings has changed. How we think about sex, emotional responsibility, and sexual responsibility; how we express ourselves as sexual beings; and how and when we talk to our children about these topics needs to change too. It's not a onetime conversation but an ongoing dialogue that should begin in an age-appropriate way when kids begin to ask questions about their body, evolving as they mature. I'm talking about facts, not values here. What you believe and how you feel about these topics are another layer of the conversation and personal to you.

It may be hard to accept, but your kids are probably more fluent in the evolving new language of sex, sexuality, and gender than you are. They're hearing these terms in health class, in the media, and online, and they talk about them with their friends. If you're going to talk to your kids about sex, make sure you're up to speed on the vocabulary of the new sexual landscape. They're more likely to listen and have an open discussion with you if they feel you actually know what you are talking about. You don't want to be that parent who doesn't know the difference between gender binary and gender fluid. The vocabulary of sex and gender is still evolving, so the accompanying list of terms and definitions may not be complete, but it should help.^{[2](#), [3](#), [4](#)}

Sex. This refers to a person's biology: female, male, or intersex. The sex of a baby is assigned at birth based on sex chromosomes (XX or XY) and their external and internal genitals. Most babies are clearly male or female. A small percentage of babies are intersex. That is, they are born with chromosomes, genitals, or reproductive glands that don't fit the clinical definition of male or female bodies.

Gender. The American Psychological Association defines gender as *the feelings, attitudes, and behaviors that a certain culture associates with a person's biological sex*. If you are born biologically a male or female, there are certain expectations of that gender based on societal norms. These norms include physical appearance—hairstyle, clothing, cosmetics. How a person acts or presents themselves is called *gender expression* and may or may not conform to their *gender identity*.

Gender identity. This is a person's perception of themselves as being a male, female, or other gender (more below). A person's gender identity may not be the same as the sex assigned to them at birth or related to their primary (internal and external genitals) or secondary (those that emerge at puberty like body hair or changes in body shape) sexual characteristics.

Binary. The idea that sex or gender only has two categories. Sex is male or female; gender is masculine or feminine.

Nonbinary. Someone who doesn't identify as exclusively female or male.

Transgender. This adjective is used to describe people whose sex that was assigned at birth or whose biological sex does not align with their gender identity. Transgender individuals do not feel their biological sex fits their identity and may feel they were born in the wrong body. This feeling of discomfort or distress is called **gender dysphoria**. Transgender people may be sexually orientated toward men, women, both sexes, or neither sex.

Transsexual. A transgender person who takes medical steps such as sex reassignment surgery or hormone therapy to change their body to match their gender. (This is an outdated term considered offensive to trans people.)

Cross dresser. A person who dresses in clothing generally identified with a different gender/sex. A transgender person may also engage in cross dressing, but cross dressing does not mean someone is either transgender or homosexual. For example, a heterosexual man may dress in women's clothing and still be attracted to women.

LGBTQ. An acronym for lesbian, gay, bisexual, transgender, and queer.

Cisgender. Someone whose gender identity and behavior align with the sex assigned to them at birth.

Gender-nonconforming. Someone who doesn't conform to traditional expectations of their gender.

Gender-fluid. Someone who does not identify as a particular gender, or whose gender identity may shift.

Gender-queer. A person who does not identify fully as either a man or a woman or declines to define themselves as gendered altogether. Someone who identifies as gender queer may think of themselves as both man and woman (bigender, pangender, androgynous), neither man nor woman (genderless, gender-neutral), or moving between genders (gender-fluid).

Queer. A descriptive term that embraces all nonbinary forms of gender, gender expression, and sexual identity. In the past the term has been used as an insult but is now often embraced as a positive term by many in the LGBTQ community.

How to Talk about Sex, Sexuality, and Gender So That Kids Will Listen

In an ideal world your kids would learn everything they need to know about sex, sexuality, and gender from you, along with value-based tools, self-esteem, and the confidence to make decisions about who and how they love. Today, however, this is often not the case. The good news is that there is a new openness about these topics. The bad news is that the information your child absorbs from the media, their friends, and other sources may not be accurate or reflect your values about sex and relationships.

I know that talking about sexuality and gender is uncomfortable and scary for many parents. It is why earlier generations talked about the birds and the bees rather than what happened between humans and let their kids get much of their working knowledge about sex and sexuality from their friends. That may have worked in simpler times, but things have grown quite a bit more complicated. Once upon a time, pregnancy was the greatest fear parents and kids had about having sex outside marriage. Today, while pregnancy is still a risk, there is so much more to be concerned about, from the physical and mental health risks of sexually transmitted diseases (STDs) to social media shaming and bullying.

The most important thing you can learn from this chapter is that honesty and openness are keys to your adolescent's mental

and physical health and their relationship with you. No matter how intense your discomfort and whatever judgments you may have about the changes in society, I encourage you to read this chapter to the end.

In Freud's day it was believed that children went through what was called the latency period of the primary school years (ages five to twelve) when developing cognitive abilities put sexuality on the back burner. We now understand that this is untrue. Although children in primary and early middle school show less interest in their sexuality, they do develop crushes and begin to masturbate, just because it feels good and they are exposed to movies, television, and social media that glamorize sexual behavior. This makes your early intervention even more important.

No matter what your values are around relationships and sex, it's important to accept that our kids are sexual beings. The old way of parenting was to shut down any but the most basic discussion and scare children into not exploring their bodies or having sex before marriage by invoking the dire physical and societal consequences of doing so. *If you masturbate, you'll go blind. You can get pregnant from sitting on a toilet seat.* It might have scared kids, but it didn't stop them from getting the information (sometimes wrong) or having sex. Your children will go their own way just as you did when you were their age. It's our job as parents to make sure they are educated, confident in their decisions, and aware of the risks and consequences of their choices.

Let's be clear: talking about sex and sexuality with your child has nothing to do with religion, politics, or whether you consider yourself a liberal or a conservative. It has to do with parenting in a way that provides a platform for you and your child to understand each other. It gives your child a safe place

to bring their concerns, questions, and problems when they arise. Talking about sex, sexuality, and gender is not just about mechanics, it is about relationships, values, and empathy. It is about knowing and understanding your child. It is about your children actually wanting to know you when they are adults because you love them, whoever they are and whoever they love.

In spite of the bravado your child may express about not caring what you think, deep down inside they care very much. If they feel ashamed of parts or the whole of themselves—if they have feelings, urges, and desires that they feel will disappoint you at best and make you reject them at worst—those feelings of guilt and shame can lead to anxiety, depression, and even self-harming behavior. No matter what they do, no matter who they are, your job as a parent is to love and accept your child without conditions.

Does this mean you have no boundaries with your children? Of course not. However, I ask you to remember that when you share your feelings and past experiences with your child who may be going through a similar experience, you are giving them a gift they cannot get from their peers, their teachers, books, or media.

Talking to your children about sex, gender, and sexuality is also a chance to talk to them about intimacy, relationships, and the physical as well as emotional responsibility to those with whom we share physical intimacy. It is an opportunity to teach them your values of self-acceptance and acceptance of others without prejudice. You can emphasize the values of mutual respect, emotional reciprocity, and empathy, and the value of sex as part of an emotional relationship rather than disconnected from it.

When one of my sons was fifteen years old, he came home from a party and announced, “I got my first kisses tonight.” He explained to his father and I that he and his friends tried to kiss as many girls on the dance floor as possible, without having any relationship with them. My husband and I explained that he still had not had his first kiss. That would happen, we told him, when he kissed someone he really cared about. One year later he came home after a date with a girl from his class and proudly told us he had his first real kiss. We were happy to celebrate that with him.

Teaching values and responsibility in regard to sex means helping adolescents connect the actions they take to the consequences of those actions. I have always taught my children that having sex comes with great emotional responsibility. Physical intimacy cannot always be divorced from emotional intimacy, no matter what popular culture may tell us. When you have sex, both you and your partner are more vulnerable and potentially attached, which means there is a greater risk of being emotionally hurt. Loving another is the most worthwhile risk one can take. However, we want to make sure that we are taking the risk with someone whom we feel we can trust with our heart and a relationship with the least likely chance of being hurt.

Teens and adolescents are not known for their good judgment. While they may not be as impulsive as they were when they were toddlers, for the most part they still don’t think about consequences, especially long-term consequences, before they act. Combine that with the hormones of puberty and misinformation, and a decision or choice can have life-altering implications.

Books written for young children that guide parents to talk about gender and where babies come from set the healthy

groundwork for a lifetime of openness about these important issues. The best time to share a book with your child or answer questions about their bodies and their gender as well as their sexuality is when they start to ask questions. If you've been talking openly about sex since your kids were young and answered their questions and responded to their curiosity about their bodies honestly, it will be easier to have the more uncomfortable conversations about gender and sexuality as they get older. Being open to their questions and answering them honestly or starting the conversation yourself lets them know they can discuss sensitive or embarrassing issues with you without being judged or criticized. Even if you'd prefer to simply hand your child a book and assume they'll read it, please talk to your child. It's *not* talking about sex and sexuality that makes the subject feel shameful and something to be hidden.

It is not easy to know what to say to your child to let them know you are available to them and want to share their concerns without alienating them. As with any emotional discussion, it's best to have this conversation when everyone is calm and not distracted, hungry, or upset. Hard as it may be, try to remember you were once a teen yourself, excited and/or scared about your new sexual feelings.

If you're nervous, it might be helpful to practice or role-play the conversation with your spouse, partner, or a close friend. They can offer feedback on your facial expressions and body language as well, which can speak more than your words.

As a parent guidance expert, my clients tell me they've found these tips helpful:

- Educate yourself on the terms currently used to describe gender and sexuality.

- My mother used to say that God gave you two ears and one mouth for a reason. Listen more than talk. Only offer advice if they ask for it.
- Remember that assumptions make an ass out of you and me. Don't go into conversations with preconceived ideas, even if you suspect your child may be struggling with their gender or sexuality or may have a health or pregnancy concern related to sexual contact.
- Don't let your worries or concern for your child overwhelm your ability to hear them out without interrupting.
- Let them know that you won't judge anything they share with you. You will love and respect them no matter what they tell you or what their concerns might be.
- Be calm and reflect on how your teen feels rather than overwhelm them with your own feelings.
- If you're upset, disappointed, or angry, share your feelings with your partner, spouse, or friends rather than with your child.
- Be calm and patient, and partner with your child in understanding what if any action should be taken.

Myths and misinformation are often the greatest cause of problems for families while accurate information can prevent a great deal of pain and anxiety for you and your children. Teens and some older adolescents don't necessarily really know (whatever they might tell you) or understand as much about the facts and mechanics of sex as they, or you, might think. When a friend's son was fourteen, she started a conversation about sex with him. "We don't have to talk," he announced. "I know everything I need to know." My doubting friend told him

if he answered one question correctly, she'd be comfortable that he did indeed know what he was talking about. If he didn't answer correctly, they would talk. She asked if a girl could get pregnant when she had intercourse for the first time. His answer: "No." They had a very long and detailed conversation after that.

One boy I treated told me that condoms aren't necessary if you pull out and that pulling out prevents STDs from spreading. A twenty-year-old girl believed that birth control pills were effective even if you missed taking the pill once or twice per week. One girl believed that you cannot get herpes if your partner had no sores, and another believed that if you put soap inside your vagina after sex you couldn't get pregnant. I could go on.

Knowledge is power, and that, I'm afraid, is what some parents might be afraid of. Giving your children the real facts of life doesn't mean that they will act on that information, now or in the future. It does mean they will have control over what they know about their bodies and their choices and what they will do with their bodies.

It's Not Something You Said, It's Not Something You Did, It's Not About You

We know that sexual identification and attraction are a combination of both biological and environmental factors and not something that is within a child's or parent's control. Gender identification is not a choice. It is a feeling, an instinct. It is hormonal as well as emotional and is organic to each child. Put another way, if your child tells you that they're gay or nonbinary, or that they feel like they were born into the wrong body, no matter how you feel about it, this is who your child is.

It's not about you. It's not something you said or did or can change.

We all have an idea of who our child is, and it is accompanied with our thoughts and wishes for their future and happiness. If your child tells you that they are gay or nonbinary or transgender and it does not match the picture in your mind, the loss of that idea of who you thought they were and who you wanted them to be is something you may have to mourn. These are normal and even expected feelings, but they are *your* feelings. If you're having difficulty, speak about this with your spouse or partner, a trusted friend, your spiritual adviser, or a therapist. This is not a burden you share with your child. Acceptance is a journey.

Between the ages of three and six, children develop romantic crushes on one parent or another, regardless of whether the parent is the same or the opposite sex. One's first romantic relationship is deeply influential to a lifetime of loving identification. When one parent or another is physically unavailable or is abusive, disinterested, or unapproachable, it can skew sexual development in one direction or another. Other children are born biologically wired to be attracted to the same sex.

As early as three years of age, children begin to recognize the differences between their bodies and the bodies of their mothers or fathers, sisters or brothers, and start to identify themselves as boys or girls. They also begin to show signs of gender identification. A four-year-old boy may be trying to be like his dad by throwing a football, or he may try on his mother's shoes and clothes, but at this point it doesn't necessarily predict how he will identify later in life.

Adolescence is a time of experimentation, including with identity and sexuality. We know that gender identity and sexual

orientation are two different things and that sexual orientation does not always appear in such definable categories and instead occurs on a continuum. As gender-fluid YouTuber Brendan Jordan says, “Sexuality is who you go to bed with, and gender identity is who you go to bed *as*.” For example, a boy might identify as heterosexual, but nonbinary (neither a boy nor a girl). Or a girl may identify as transgender and gay.

According to the CDC, 1.3 million kids, or roughly 8 percent of all U.S. high school students, report being lesbian, gay, or bisexual. If your child identifies as lesbian, gay, bisexual, asexual, or transgender, for example, understanding and supporting their journey can be a challenge, no matter how progressive or open you think you are. Many parents feel uncomfortable with these differences and on some level may reject them. They may feel it’s their fault. They may get angry at their child and feel that the child is doing it to deliberately cause pain.

Conflicts are almost inevitable, especially if your child’s choices about sexual activity or sexual identity don’t align with your values, but how you handle these conflicts can mean the difference between estrangement and a continuing connection, between depression and emotional security. It is critical that parents are nonjudgmental when discussing gender and sexual orientation with their children. A high percentage of children who identify as nonheteronormative suffer from depression and are prone to suicidal thoughts.⁵ It is hard enough being different from many of your peers and your family, but even more difficult if your family and those closest to you judge you or do not accept who you are. The difference between a depressed or suicidal teen who struggles with conflicts over

their gender and sexuality is often the love, understanding, and acceptance of their parents.

Pauline and Gary came to see me when their fourteen-year-old son, Jasper, came out to them as gay. Both parents were having a hard time believing that their son was gay. Jasper had always been so “normal.” He played baseball and basketball and had a lot of friends. Girls had always been attracted to him, Gary said. But, Paula reminded him, he never was interested in any girl in particular, like his friends were. And she had noticed how physically affectionate he was with his best friend, John. In addition, they blamed themselves for what they saw as a defect. Paula wondered if her close and indulgent relationship with her only child was the problem while Gary told me that if he’d spent more time with his son he was sure this wouldn’t have happened.

They were also upset with themselves for how they reacted when Jasper came out to them. Jasper told them he had known he was gay since he was eleven and lived in fear that if he told his parents they wouldn’t love him anymore. Unfortunately, his parents’ initial reaction had been to tell their son he didn’t know what he was talking about, that he couldn’t possibly be gay, and that he was only trying to hurt them by saying these things. Jasper responded by going to his room and refusing to come out for twenty-four hours. When he did, he avoided his parents as much as possible and spoke to them only if he absolutely had to. This went on for a week before Pauline and Gary came to me for help.

To their credit, Pauline and Gary wanted to repair their relationship with their son. I asked why they couldn’t accept that their son was gay. We talked about their worries and fears. They were afraid that others—especially members of their church community—would reject him and that Jasper’s sexuality was a reflection on them as parents. They worried that their son would never find love or have a family, that they would not have grandchildren.

I pointed out that their son was the same Jasper as before he told them he was gay. Jasper’s homosexuality was as much a part of him as his sense of humor, his empathy, and his intellect. There was nothing that they did or didn’t do that “made him that way.” They couldn’t change his sexuality any more than they could change his blue eyes. Their love would allow their son to love and be the best self he could be. Their fears and worries were an obstacle to expressing their love and supporting Jasper, who had his own fears of being rejected and judged by others and not finding love. They knew several gay couples, one of whom was married and had children; why couldn’t Jasper do the same?

Gary and Pauline apologized to their son. They told him that while they might continue to struggle with their own feelings, they loved him and would always love him, no matter whom he chose to love.

Bullying and Violence Against LGBTQ+ Adolescents

Gender or sexual orientation diversity may be more widely accepted than ever, but LGBTQ+ persons are still in the

minority. It can be painful for younger adolescents especially; their school peers and even friends can be cruel about differences. LGBTQ+ adolescents can be a target of bullying and violence. A national survey of over 8,000 students between the ages of thirteen and twenty found that 64 percent of students feel unsafe at school because of sexual orientation prejudice and 44 percent feel unsafe at school because of gender expression. Over 60 percent of youths did not report incidents to school staff, often because they believed little action would be taken or that the situation would be made worse by reporting it.

If your child is LGBTQ+, this makes your love and support all the more important. According to the CDC, nearly 18 percent of lesbian, gay, and bisexual students said they had been raped at some point in their lives. They were twice as likely to be bullied, both online and at school. They were more than twice as likely to stay home from school because they anticipated being attacked on the way to or at school. Almost 30 percent had attempted suicide, and 60 percent reported feeling “sad or hopeless.” They used hard drugs far more often than their straight peers: 6 percent used heroin at least once, and 5 percent reported using intravenous drugs.

Transgender Kids

It can be hard to hear when your child tells you that they are gay or bisexual. It can be a challenge to recognize that your child may not have the life you envisioned for them. It may be hard on your ego to accept that your child may be different from you.

Even harder to hear is that your child feels they were not born in the correctly gendered body or that they are

transgender. This is more complicated and often more challenging for a parent to navigate. You may be afraid that others will judge you or your child. You may be deeply concerned about the pain that lies ahead for your child in a rapidly changing world that is still full of judgment and controversy. You may wonder how you can help them with the decisions they will want to make if they want medical interventions, and worry about the financial issues. I always encourage parents of transgender children to educate themselves as much as they can, and to get therapy for themselves to help them accept and relate to the decisions that their child may have to make over the coming months and years. Acceptance, love, and understanding will protect your child and your relationship with your child going forward.

The medical interventions—high doses of hormones that must be taken for a lifetime and radical surgeries—necessary to change a male body to a female one and vice versa should not be undertaken lightly. Some medical professionals believe these interventions are appropriate before a child reaches puberty. This is a controversial position because the genital surgeries cannot be reversed and there's a great deal of uncertainty about the long-term effects of taking the hormones necessary to maintain the transition. Many medical and mental health professionals believe that these decisions should be made when psychological identity is less fluid and more stable. They believe it is better for a transgender person to live as the gender they identify as and fully understand the ramifications of their decision and the medical risks involved before making these life-altering decisions.

When Jane was twelve years old, she announced to her parents that her name would now be Jack. She had always felt more like a boy than a girl, she told them, and now

she wanted to live like one. She had been afraid to talk to her parents about her feelings, but she was so unhappy that she couldn't hold it back any longer.

Candace and George were surprised and upset. Even though their child had always been a tomboy, preferring pants and shorts to dresses and happier playing and roughhousing with boys, they believed it was a phase Jack would grow out of. Now that it was clear it wasn't, they didn't know what to do. Candace's first reaction was to ask, "What did I do to make you feel this way?" while her husband worried about the reaction of their family and friends. The rest of the conversation did not go well, and Jack stormed back to his room angry and in tears.

Candace and George came to see me. They loved their child and understood that they needed help both with their own feelings and to learn more about what their child was going through. I encouraged them to send Jack to a therapist who had experience with adolescents and gender issues, while they spent time in parent guidance with me learning how to accept "Jane" as Jack.

It was challenging for them not to blame themselves or each other for what they saw as an aberration but rather accept their child's identity as a unique part of who he was and how he was born. It was hard for Candace and George to lose their daughter as they knew her, particularly for Candace. I told them it was normal that they should mourn the loss of the child they knew, and I reminded Candace and George that their child was the same person they have always known and loved. Jack wanted to be seen for who he was and who he felt himself to be, and it was that experience that would help them cope with the challenges to come. Candace and George agreed that they would call "Jane" Jack, and use the pronouns he/him/his instead of she/her/hers.

Candace and George expressed concern for the social rejection and challenges Jack would face. I pointed out that Jack's ability to function in the world would depend on his parents' unconditional love and acceptance, and their ongoing support.

Jack told his parents and therapist that he wanted to begin masculinizing hormone therapy to prepare for the possibility of gender affirmation surgery in the future. I recommended that, before he begin medical treatment, he continue therapy to confirm and live as his chosen identity before altering his body. While some doctors do prescribe hormone therapy for younger adolescents, most suggest waiting until the person is sixteen.

Candace and George came to accept that they were not responsible for Jack's feelings and could not change them, no matter what they wanted for their child. Ultimately, their love for Jack trumped every personal bias.

Candace and George met with their son's school principal, guidance counselor, and teachers to discuss Jack's identity and how the school would support the change and deal with any episodes of bullying. They spoke with their rabbi, family, and friends about Jack, emphasizing that they accepted and supported their child and expected everyone else to do the same.

My Kid's Not Having Sex!

First, let's define what we mean by "having sex." The first thing most parents think of is genital intercourse, but many teens and adolescents aren't having intercourse. They may,

however, be having other “adult” sexual experiences, like oral sex and, yes, anal sex.

It is highly probable, if not certain, that your child will have sexual experiences without your knowledge and approval. A 2017 National Center for Health Statistics report revealed that more than half of U.S. teens have had sex by the age of eighteen and virtually all sexually experienced female teens (more than 99 percent) have used some form of birth control. According to Planned Parenthood, the current historic lows in teen pregnancy and birth rates in the United States we know are due to the increased use of contraception.⁶

Many parents feel that talking about birth control, buying condoms for their son, or taking their daughter to the ob-gyn for birth control will signal their approval of sexual activity and encourage their child to have sex. This is a myth. Educating your child about sex along with values-based teaching opens the door to a discussion about the responsibilities that go hand in hand with sexual activity. Those conversations may be more of a deterrent than an enticement. They can also give your child the ability to say no in situations where they could feel pressured to do something they’d rather not do.

If parents can acknowledge they have little control over their teens’ sexual experimentation, they can accept that the control they do have may be to influence how much risk their teen takes. This compromise can be the difference between your child getting pregnant, getting someone pregnant, or getting an STD.

STDs Are a Fact of Life

There was a time when the biggest risk of having sex was an unwanted pregnancy. Most people were not at risk of catching a

sexually transmitted infection unless they frequented prostitutes or were extremely sexually promiscuous.

Today, that has changed. First, there are more sexually transmitted diseases. Some of them, like HIV/AIDS, can be fatal; others, like genital herpes, can't be cured. If untreated, some, like pubic lice, are merely uncomfortable and embarrassing. A disease like Chlamydia, however, can cause irreversible infertility, and the human papillomavirus (HPV) can lead to cervical cancer.

Talking to your kids about STDs is an essential part of their education. You can't hide under the covers on this one. They're probably hearing all about this in health class, and you want to be informed, not defensive, and calm if they come to you with questions.

While your child is under eighteen, you are responsible for their health and well-being. If they had the flu or broke their ankle you would make sure they got the medical care they needed. If your child has an STD, whether you approve that they've been sexually active or not, you have the same obligation. If they are older and still covered by your health insurance, you could find out when you get a bill. Wouldn't you rather they were able to talk to you first?

Dan and Juliet were blindsided when their fourteen-year-old daughter Suzanna was diagnosed with herpes. Juliet had taken Suzanna to her pediatrician because she thought she had the flu. After the examination, the doctor called Juliet into her office and told her that based on her daughter's symptoms, including the genital sores (which Suzanna hadn't told her about), she was diagnosing Suzanna with herpes. Juliet was horrified when she found out that her daughter had contracted the virus from having unprotected sex with a seventeen-year-old boy she had met online.

Dan and Juliet's first response was disbelief that their daughter was having sex, relief that she wasn't pregnant, then anger at their daughter and shame should anyone find out. Suzanna was embarrassed and depressed, not just about her diagnosis but her parents' knowledge that she'd had sex.

When Suzanna's parents came to me, they told me their daughter had always wanted to be the center of attention. Her parents knew she had been a flirt with boys

and men of every age since she was ten, and more recently had become obsessed with TikTok and Instagram, posting images of herself in a bikini and in provocative poses. Her parents were aware of her behavior, but they ignored it, hoping she would grow out of it.

I referred Suzanna to an adolescent therapist. The truth was that she had needed therapy long before her parents found themselves in my office. When Suzanna was five, her father had an affair and her parents separated, then reconciled six months later. Her older brother, who was thirteen at that time, started drinking and smoking marijuana as a way to cope with the family trauma. Suzanna felt lost and ignored amid her parents' battles and their focus on her brother's substance abuse. She was very social and, though quite pretty and physically mature for her age, very insecure about her appearance. She found it easy to attract the boys at her school and craved their attention the way her brother had craved marijuana and alcohol. The physical connection substituted for the affection and attention she wanted from her parents.

Dan and Juliet realized that if Suzanna was going to change her behavior, they also had to change theirs. They insisted that her brother also go into therapy to deal with his addiction issues. They educated themselves about herpes so that they could help Suzanna treat and manage the virus. They understood that being angry or shaming her about her illness would push her further away and reinforce that she would not receive the affection and support she wanted at home, or from other appropriate partners in the future.

While it was not required by law that Suzanna inform her other partners that she had herpes, her parents believed it was the right thing to do. Fortunately, she had only had sex with two other young men. Suzanna wanted to use one of the several anonymous online services to do this, but because of her age and concerns for her safety, her parents and therapist agreed that her father should make the calls.

In therapy, Suzanna learned to distinguish between her illness and herself; she was not her illness, and she was still both loveable and deserving of love. Suzanna was happy with her parents' newfound emotional presence, and also knew that with the virus she had to change her sexual behavior as well. She was able to shift her focus to her academics and school activities, and developing genuine friendships with girls and boys.

If your child comes to you with symptoms of an STD or you notice any symptoms, have your child tested. The earlier an STD is diagnosed, the more likely it is that it can be treated, cured (if possible), or managed, and the less likely a person is to suffer lingering side effects. Your child's partner(s) also have to be informed. The more your child trusts you, the more likely they are to come to you if something is wrong.

Talking about sex, sexuality, and gender with your adolescent is not easy, yet the openness, acceptance, and love you show them will provide a foundation of trust, respect, and honesty

for your relationship going forward. As hard as it is, accepting that our children are like us yet different than us—attached to us but separate from us—helps to create lasting bonds and intimacy with our children well into adulthood. Whether we approve of or like their choices or their lifestyles or not, we have no control over who our children will become. We owe it to them to give them a solid foundation of love and security so that they can make the best decisions for themselves going forward.

CHAPTER 5

ANXIETY AND DEPRESSION

They Can Happen to Anyone's Child

No parent wants to hear that their child is suffering from anxiety or depression, but it is more common than you might think.

Trina and Carl came to see me because their daughter Pamela was showing signs of anxiety. Trina told me her daughter had always been a sensitive and nervous child. Even in elementary school, she had wanted her homework to be perfect. She studied much of the time and preferred reading books for pleasure and improving her writing skills when other kids were playing outside.

Pamela had skipped a grade in primary school. Though she was younger than her classmates in middle and high school, she was consistently placed in honors classes and had a full schedule of extracurricular activities.

In her sophomore year, Pamela started showing visible signs of stress. She began to have migraine headaches and had difficulty falling asleep at night. When she had a panic attack at school, Pamela's parents met with her guidance counselor. She told Trina and Carl that although Pamela was an academic star, some of her teachers had commented that she would get upset when she answered a question incorrectly in class or received less than a perfect score on a paper or test. The counselor was concerned and suggested Trina and Carl consult a professional.

When Trina and Carl came to see me, they immediately asked about medication. I told them Pamela should be evaluated by an adolescent psychotherapist, who would also begin talk therapy, while Trina and Carl would see me for parent guidance.

Like many parents, Trina and Carl had defined success for their child as being exceptional: excelling in school and extracurricular activities and having many friends.

Both Carl and Trina came from families where their parents were not emotionally available and had very high expectations of achievement. In our sessions, they became aware that they saw their daughter's achievements as a barometer of how successful she was and how successful they were as parents. They were so invested in her getting into the "right" college that they lost sight of the fact that the "best" might not be the best for Pamela. They both admitted that they felt guilty about not spending more time physically present with or emotionally available to their daughter, and like their own parents, they never discussed their own negative feelings openly. If

Pamela tried to express her worries or fears, they would dismiss her concerns or change the subject to a happier topic.

Carl and Trina, like most parents I treat, love their child. However, they didn't recognize that their own painful experiences growing up were affecting how they were parenting Pamela, and how those patterns contributed to their child's anxiety. I empathized with their feelings of loss of their seemingly perfect daughter, and with their remorse that if they had only been there more for her, she might not have been struggling. I reassured Trina and Carl that they now had an opportunity to help their daughter before she left home for college.

Through our sessions, Pamela's parents were able to be clear with her that they didn't care about her test scores as long as she tried her best. They made it clear they would love and support no matter where she went to school. They agreed to eat dinner together at least three nights a week, and everyone was home by 6:00 pm on those nights. They put "family dates" in their calendar when they focused on doing things together, letting Pamela decide the activity. They put away their phones and computers during meals and when Pamela wanted to talk or needed their attention. Both parents made an effort to have one-on-one time with her.

Pamela dropped her honors classes in favor of regular classes and gave up some of her after-school commitments. She began looking at colleges that were less competitive and offered a more creative approach to learning. When she made these changes, her anxiety decreased, though she still occasionally had a bad night when she could not sleep.

Pamela looked at her parents' achievements and believed she couldn't measure up to their accomplishments or expectations. It is one thing to feel competitive with your peers and quite another to feel competitive with your parents.

Carl, Trina, and Pamela's story is not every family's story, and not every anxious teen needs treatment.

Not Every Child Who Feels Worried Is Anxious

Distinguishing normal worrying from anxiety isn't always easy since all of us, adults and teens, occasionally become anxious or have a blue day. Anxiety and sadness can both be useful, signaling that we need to stop and examine our feelings about a situation or take a break to care for ourselves. But even for the emotionally healthy teen or one who has no history of mental disorders in the family, adolescence can be traumatic—physically, emotionally, and socially. An unexpected failing grade for a high-achieving kid, a first heartbreak, the stress of

living away from home for the first time, divorce, or the death of a loved one can all leave your child vulnerable.

Identifying when your child is overwhelmed by academic or social pressure can be a challenge. As a parent, the better you know your adolescent and the more physically and emotionally present you are, the greater the chance you can recognize trouble signs early—and early intervention is the key to helping your teen. A good enough parent cannot always prevent bad things from happening, nor can they control their child's response to stress or adversity. They do, however, know how to help their child when bad things happen or the child is overwhelmed by stress.

You should be concerned when anxiety or depression become your child's constant companion, expressing itself in symptoms that make a difference in their behavior and interfering with their daily activities. The difference between mild and situational anxiety, which may be an appropriate response to something stressful—your kid is anxious about a final English exam or sad because their best friend went to the movies with someone else—and something more serious is the intensity of the symptoms and how long they last. Moping around the house or being irritable for a day or two isn't cause for worry. But an adolescent who refuses to see their friends for two weeks or more, or one who has a full-blown panic attack anticipating a science test, may be suffering from a clinical disorder that should be treated without delay.

Finding out that your child is suffering from some form of mental illness is a parent's nightmare. At the root of most mental disorders that we see in teens today is some form of emotional breakdown due to anxiety and depression. Anxiety is an intense emotion related to fear and stress. It's the body's signal to mobilize when you are under threat, either perceived

or real.¹ All babies experience fear and anxiety and even have hysterical feelings: Where's my mother? Why isn't she here *right now*? I'm hungry, why aren't you feeding me? Those feelings and our body's reaction to them (see [page 64](#) on the limbic system) are survival mechanisms to get our needs met.¹
² When we're no longer infants, however, if we experience intense or persistent and unrelenting anxiety, it becomes a mental health issue that should be treated. Anxiety and depression, which occur on a spectrum of mild to severe, are emotional conditions unto themselves but are also causes for many of the symptoms and manifestations of such disorders as attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), and bipolar disease.

Anxiety and depression are different ways to express the inability to regulate emotions and cope with stress, but they overlap and often are intertwined. When fearful or anxious feelings are left untreated for too long, intense anxiety can lead to depression or the internalizing of fear or feelings of despair. Anxiety and depression can occur separately or together. An adolescent who is anxious because of internal stressors (low self-esteem, perfectionism, harsh self-criticism) or external pressures (parental, social, or academic) may develop symptoms of anxiety but not depression. However, if the anxiety is not treated, feelings of helplessness and hopelessness may lead to depression. It's common for teens who struggle socially or with learning or sensory processing issues to develop anxiety and depression if their challenges are not addressed.

What Is Anxiety and What Does It Look Like?

Anxiety is a feeling of threat from dangers or preoccupation over losses in the future that may never happen. The troubling statistics clearly indicate that anxiety is on the rise in adolescents. According to a report by the Child Mind Institute, anxiety disorder diagnoses increased by 17 percent between 2008 and 2018 in children and adolescents. Though this report estimates that 30 percent of youth suffer from anxiety, roughly 80 percent of those children and adolescents do not receive any treatment (or, stated in reverse, only 20 percent receive treatment). This study compared high school students in the 2010s to those of the 1980s; those from the 2010s reported a dramatic increase of symptoms of anxiety such as more trouble sleeping, shortness of breath, and issues with thinking and memory, and were twice as likely to have seen a mental health professional.

How Do I Know If My Child Is Anxious?

If your child exhibits a cluster of symptoms of one of the conditions discussed in this chapter for two weeks or more, they may need treatment.³ Do not rely on your pediatrician alone. This is the time to ask for a referral to a psychotherapist who specializes in treating teens and adolescents:

- Nervousness, restlessness
- Feelings of danger, panic, or dread
- Elevated heart rate
- Rapid breathing or hyperventilation
- Trembling or muscle twitching
- Weakness or lethargy
- Excessive sweating

- Difficulty with attention
- Sleeplessness or changes in sleep patterns, including having difficulty falling asleep or staying asleep
- Loss of appetite or eating excessively
- Obsessive thoughts that repeat and are not necessarily based in reality
- Panic attacks

This Is Your Kid's Brain on Stress

The adolescent brain is rapidly changing and growing, adding new connections and removing unused or unnecessary ones.⁴ This period of dynamic change is also a time of unique vulnerability for the brain, which is particularly susceptible to anxiety or depression if subjected to extreme stress. In some cases, stress can even impair the normal process of brain development.^{5, 6}

As I discussed in Chapter 3, stress regulation is the responsibility of the limbic system, a group of brain structures that secrete hormones that affect our behavior. The limbic system regulates how we react to fear, respond to rewards, and pursue our goals. When we are stressed or afraid, the amygdala signals the hypothalamus to indicate to the pituitary gland to tell the adrenal glands to release hormones like cortisol and adrenaline (epinephrine) into the bloodstream. This is the hypothalamus-pituitary-adrenal (HPA) axis. When the real or imagined threat is over, another part of the limbic system called the hippocampus shuts down the stress response by reducing or stopping the production of adrenaline and cortisol.

Anxiety is a state of hypervigilance; when an adolescent experiences chronic stress, the amygdala enlarges and gets

stuck in one position and continues to signal the presence of an immediate threat.⁷ When this happens, the hippocampus, or shut-off valve, shrinks and cannot stop the flow of stress hormones and an adolescent is constantly in a state of high alert. If the hippocampus shrinks, not only is its ability to regulate the stress response impaired, but the brain's ability to process the memories associated with stressful experiences is also impacted.⁸

When the stress system is continually activated, the amygdala, which had enlarged to deal with the demand for stress hormones, is compromised and the less-than-active hippocampus becomes even less functional. The limbic system becomes blunted, or hypovigilant. The brain throws up its figurative hands and says, "Enough!" These adolescents then can't remember or associate fear with their actions so they end up taking dangerous risks, often becoming depressed without the healthy regulatory functions of the brain intact; this leads them to repeat risky behavior, even in the face of negative consequences.^{7, 8}

The PFC, or social-emotional part of the brain, is responsible for emotional security, self-reflection, judgment, impulse control, emotional memory, and reward response. It isn't fully developed until a person is twenty-five years of age. In depression, the PFC becomes underactive, and the limbic system goes into overdrive, pumping out stress hormones. Essentially the balance is off because stress overwhelms the PFC's ability to help with emotional regulation. The combination of a low- or nonfunctioning limbic system and an underactive PFC is a perfect recipe for anxiety and depression.⁹

But Why My Child?

The best defense against anxiety and depression is emotional resilience, the ability to cope with stress. The more emotionally secure your teen is when they enter puberty and adolescence, the better off they will be. Today, the process of becoming an adult is complicated by social and cultural issues that push our kids to their limits and, too often, beyond. Some teens are at risk because of difficult family relationships, a history of neglect or abuse, or a family history of anxiety, depression, or other disorders. Others, especially highly sensitive kids, repress their feelings of vulnerability as long as they can until they simply can't hold it together any more under the physical and emotional strain of growing up.

Sometimes there's a genetic component. We know that depression and anxiety can run in families but not the way you may think. Trauma, including loss, or stress—social isolation, physical illness, family dysfunction, and psychosocial stressors—can trigger or activate the genes associated with these conditions, especially in sensitive children. Having a genetic component to depression and anxiety means some of us are born more vulnerable to stress or challenges, internally or externally. This sensitivity can first be seen in behavior as young children and later as teens. If your child was a fussy baby who was hard to soothe—what pediatricians used to call *colic*—sensitive to light, sound, or touch; had eating or digestive issues; or had frequent, intense tantrums, then you probably have a sensitive child. As a teen and young adult, they may experience extreme bouts of moodiness, difficulty dealing with disappointment or rejection, or trouble regulating their anger or impulsiveness; become withdrawn when they're stressed; and have trouble sleeping and regulating their eating. This same research shows that a parent's sensitive nurturing in the early years can neutralize the expression of this genetic

sensitivity, and that the expression of these conditions is not a foregone conclusion if parents are involved and present. Just as a parent helps regulate a toddler's emotions, in this second critical window of brain development that occurs during adolescence, a parent has another chance to help their child in the same way. Research also shows that psychotherapy can restructure the architecture of the brain through the empathic connections the therapist forms with the patient.¹⁰

The first line of intervention if your child needs to be treated for anxiety is evaluation by a psychotherapist who specializes in adolescence. The most effective treatment is talk therapy, combining behavioral and psychodynamic—also called *interactive*—therapy. Sometimes medication can be prescribed in conjunction with talk therapy, but it should be used as a last resort and is most effective as a temporary measure. It should only be used as a bridge to self-awareness and self-regulation; it is not a fix in and of itself. Any doctor who treats your child—preferably one who specializes in teens and young adults—and prescribes anxiety medication should have a plan for weaning your child off the medication when it's no longer necessary.

Treatment Options for Anxiety

If your child's symptoms are mild, the best option is for them to live at home and participate in talk therapy with a qualified therapist. If necessary, they can also be treated with medication under the close supervision of a psychiatrist who specializes in children and adolescents.¹

Psychiatric medication is usually covered by insurance, but talk therapy can be expensive. Most insurers will cover a limited number of therapy sessions but may refuse longer-term treatment. Paying out of pocket is money well spent; therapy

addresses the root cause or causes of your child's distress and can give them the tools to deal with anxiety and stress in the future. There are low-fee and sliding-scale options for therapy. Training institutes for therapists frequently offer low-fee referral services, often with highly qualified therapists going through advanced training. You can find a list of some of these in the Appendix at the end of the book.

If your child's symptoms are more severe and debilitating, their therapist may suggest a day treatment program. Your child will live at home but go to a clinic during the week. Each day they will have individual and group therapy. If they need psychiatric medications, a doctor in the program will prescribe them. While they are in the program, your child will not go to school. The programs are usually covered by insurance.

A child who is in crisis or suicidal may be admitted to a hospital. The goal of the doctors in the hospital will be to evaluate, diagnose, and stabilize your child's condition, then create a treatment plan to be followed after discharge. A hospital stay rarely lasts more than ten days.

If your child is determined to be an ongoing risk to themselves or others, or if they have a breakdown and can no longer function, an inpatient environment may be best. No matter what the diagnosis, you want to find a facility that specializes in children and adolescents. These programs treat patients with talk and other forms of therapy and, if appropriate, medication. Inpatient or residential programs are short stay—thirty to sixty days—or long term—up to a year. Insurance usually covers acute treatment in a hospital and short-stay residential treatment. Short-stay facilities usually don't incorporate schooling in their programs, but some long-stay residential programs for teens do.

Some day and boarding schools specialize in children and adolescents who have emotional, behavioral, and mental health issues. They often offer both day and boarding programs. These schools give kids an environment removed from psychosocial stressors and offer a holistic approach to treatment.

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a form of anxiety that may occur in extreme cases of fear-inducing trauma such as rape, physical violence that includes combat experience, or any time a person feels their life and safety are threatened.³ An isolated traumatic incident isn't the only cause of PTSD: chronic bullying, conditions of extreme poverty, the constant threat of violence, and continuing sexual, physical, or emotional abuse or neglect are all recognized causes. The reaction to the physical or psychological trauma results in continuing flashbacks and memory loops, like a scary movie you can't turn off. These intense memories evoke the same emotions and fight-or-flight response that the original experience did, even when there is no real threat, and can last for years. The National Institutes of Health estimate that 5 percent of adolescents have PTSD, and about 1.5 percent are severely impaired. More girls and young women (8 percent) suffer from the condition than boys and young men (2.3 percent).

Someone suffering from PTSD may have many of the same symptoms as someone suffering from generalized anxiety. However, the intensity and repetitiveness of the memories and flashbacks and the feelings associated with the memories are unique to PTSD. A tragic example of what PTSD can do occurred in the aftermath of the Parkland and Sandy Hook school

shootings, when two surviving students at Parkland and the father of a Sandy Hook student committed suicide.

A child who has a cluster of these symptoms for more than two weeks should be evaluated for PTSD:³

- Flashbacks to or reliving the original traumatic event or events
- Vivid nightmares
- Panic attacks
- Intense feelings of dread, even if there's no obvious danger
- Aggression for no apparent reason
- Episodes of dissociation (temporary disconnection from self, others, and even reality)

PTSD responds well to a combination of talk therapy, medication, and eye movement desensitization and reprocessing (EMDR) therapy.¹¹ Meditation is also effective as it can alter the brain's reaction to a constant state of fear. As with other forms of anxiety, antianxiety medication can be useful in conjunction with other forms of therapy as long as debilitating symptoms persist.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is an anxiety disorder. In its purest and most intrusive form, OCD can be seen as a way to self-manage severe anxiety. There are components of OCD in eating disorders and other addictions where repetitive unhealthy behaviors are used as a way to temporarily self-soothe and find comfort from anxiety. OCD used to be considered rare in youth, but it's now estimated that 1 to 3

percent of children and adolescents have symptoms of the disorder.¹²

OCD often appears first as peculiar and repetitive or superstitious behaviors or rituals based on intrusive and obsessional thoughts.³ For example, a child may not leave the house until they've walked around the couch four times. An otherwise typically messy teen may insist on washing their hands multiple times before eating for fear if they do not complete these rituals something terrible will happen to them or to those they love, or they will not get an A on their exam or do well in their soccer game. While these behaviors may bring short-term relief from anxiety, they don't relieve the root cause. Over time the behaviors themselves can cease to feel comforting and generate anxiety. If a ritual is interrupted, or can't be completed, a child may become agitated and upset, and will not calm until they've completed the ritual. Tics like excessive blinking or facial contortions are also common.

OCD symptoms can come and go depending upon the level of stress or anxiety a teen is experiencing. Teens with OCD are often ostracized by their peers because they are perceived as socially or behaviorally strange. Social isolation can exacerbate their symptoms.

If your child exhibits a cluster of the symptoms below for two weeks or more, they may have OCD:³

- Extreme fear of germs or contamination
- Uncontrollable intrusive and aggressive thoughts ranging from negative self-talk—*I'm ugly; I'm stupid; No one will ever love me*—to self-harm or harm to others
- An extreme need for symmetry or order in their environment

- Excessive handwashing or cleaning
- Repeatedly checking things: checking that the stove is turned off or the door is locked, for example
- Compulsive counting

OCD responds well to a combination of talk therapy, parent guidance, cognitive behavioral therapy, and medication, as well as meditation. A combination of these treatments is often better than any one of them alone.

Depression and Depression-Related Conditions

Depression is a response to feelings of loss in the past that are felt deeply in the present. We all have sad moments over losses, but when these moments turn into days, weeks, and months, we know there is a problem. There is no depth of emotion without acknowledging moments of loss and sadness, and while moodiness and dramatic mood swings are normal for teens, if your adolescent experiences these feelings intensely and chronically, they may lead to clinical depression.

Andrew was nine and his brother, Max, was seven when their parents divorced. The boys lived through the screaming matches and slammed doors while their parents were married and the arguments over custody and financial arrangements while the divorce was in progress. Three years after the decree became final, Andrew, now twelve, and Max, ten, lived with their mother and spent every Wednesday and every other weekend with their father.

Andrew had always been a sweet, energetic, athletic boy who did well in school. When his father moved out, Jim and Ellen noticed changes in his behavior and personality. On weekends, he wouldn't get out of bed until after noon, and rather than hanging out with his friends, he retreated to his bedroom and closed the door, only coming out to eat. He began to have trouble concentrating in class, and Ellen was called to school for a conference because he wasn't handing in his homework. He quit the baseball team. He was visibly sullen, withdrawn, and often angry.

His parents had been so wrapped up in their own emotional drama and guilt that they didn't see that Andrew had been devastated by the divorce until it became obvious to everyone, including his teachers at school. He was still grieving the loss of

his family, and he missed his father—and was exhibiting classic symptoms of depression.

In my sessions with Jim and Ellen, it became apparent that they still had a very contentious relationship. They constantly competed for their children's attention.

In his therapy sessions, Andrew was able to express the impact on him of the loss of an intact family and his feelings of abandonment. The constant conflict and sniping eroded Andrew's sense of safety and emotional security. He felt that his parents cared more about winning their ongoing fights than about his brother and him. He told his therapist that his parents would have been happier if he and Max hadn't been born. He worried that he didn't see enough of his father and was afraid that one day Jim would leave and never come back.

Jim and Ellen were eventually able to admit, express, and embrace their own feelings of sadness and loss about their marriage, which was the first step toward talking with their son about them and eventually allowed Andrew to talk about his feelings.

I encouraged both parents to spend more time with Andrew, doing things he enjoyed. I suggested that sharing their own feelings could be an opening for Andrew to talk about his. They made a conscious decision to change how they talked to each other and dealt with disagreements in front of their children. They also decided to give Andrew and Max more choices about the custody arrangements.

It took several months before Andrew trusted the new relationship with his parents. He began to show interest in getting together with friends again, dove back into his schoolwork, and spoke to his baseball coach about what he would need to do to rejoin the team.

What happened to Andrew can happen to any child who suffers from an extreme loss or trauma. Teens rely on the stability of their world for their emotional security, and any changes can be experienced as loss. Not every child experiences loss—a divorce, loss of a loved one, a change of school or residence, health issues, an ill parent or sibling, even the birth of a sibling or a parent going back to work—in the same way. Nonetheless, it is important to keep an eye out for symptoms of depression when your child suffers a significant loss or setback.

A 2016 study published in *Pediatrics* found that the number of teens who had reported a major depressive episode in the previous twelve months jumped from 8.7 percent in 2005 to 11.5 percent in 2014. That's a 37 percent increase in just ten years. A study by the CDC noted that the suicide rate has increased from 11.3 to 12.6 suicides per 100,000 in that same

period. A longer-term view published in *Social Indicators Research* in 2015 shows the same troubling increase. If your child exhibits a cluster of the symptoms below for two weeks or more, it should be a cause for concern:

- Fatigue
- Excessive isolation
- Extreme sadness
- Difficulty getting pleasure from any activities or interests
- Obsessive thoughts over losses and feelings of remorse
- Feelings of hopelessness or despair
- Sleeplessness or excessive sleep
- Appetite loss or weight gain
- Suicidal thoughts or thoughts of self-harm or harm to others³

Depression responds well to psychodynamic or talk therapy, which is effective in healing early relationship issues and losses, many of which are at the root of mild to moderate depression. Medication can be a supplemental part of treatment but should not be a first-line treatment and is better used as a bridge to increase self-awareness and understanding of the underlying causes of the condition. If medication is used alone and not in conjunction with talk therapy, there will be no long-term change to the patient's condition because the underlying cause or causes are not being addressed. Medications for depression can have side effects, which are sometimes tolerable in the short term but harder to deal with in the long term.

In extreme cases of severe depression, new treatments include magnetic therapy, which has shown some promising results, as well as the use of hallucinogenic drugs under the careful supervision of a physician.^{13, 14} Electroconvulsive therapy (ECT), which was formerly called “shock therapy,” can also be effective in alleviating severe and persistent symptoms that have not responded to talk therapy and medication. ECT uses electrical shocks to the brain to induce seizures. Although it once had a bad reputation, several studies including one by NCBI showed that, when properly administered, it is a safe and effective treatment.¹⁵

Suicidal Thoughts and Actions

Depression in its most extreme form can result in extreme hopelessness and talk of suicide, self-harm, or doing harm to others and should *always* be taken seriously. Although common for teens to think about and even talk about killing themselves when they feel depressed, it is more concerning when they have a plan and have put thought into the method or have access to medications or firearms. If your child expresses these thoughts, ask them if they had thought about how they would carry out these threats. If they can’t tell you or respond that they would never actually carry it out, call their pediatrician immediately to get a referral for a therapist.

If they *can* articulate a plan of action, run, don’t walk, with them to the emergency room or call 911. If you call the police, you must be clear that your child has the means and the intention to harm themselves or others.

HIPAA and Your Young Adult Child

If your child is over eighteen, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits their doctor from sharing confidential medical information, which includes information about their mental health, with you, unless your child has given them permission to do so. However, if you believe they have a plan and the means to harm themselves or others *call 911 or the police immediately.*

Mania or Bipolar Disorder

Mania, or manic behavior, often but not always accompanies depression. Manic behavior is a hyper or frenetic emotional state. Teens can suffer from depression without alternating between depressed and manic behavior, but manic episodes are always associated with depressive episodes: what goes up must come down. The cycling between depression and mania is called *bipolar disorder*; it is the most extreme form of depression and a serious form of mental illness. Bipolar disorder often has its origin in brain chemistry and often shows up in late adolescence or a person's early to midtwenties.

Bipolar disorder can be a more dangerous and life-threatening disease than depression alone due to the fact that adolescents who are suffering from a manic episode may take great and sometimes life-threatening risks.

As with other conditions, a cluster of the following symptoms for two weeks or more can indicate your child is experiencing bipolar disorder.³ Get them to an emergency room or a psychiatrist as soon as possible.

- Hyper- or frenetic activity, or markedly increased energy

- Feelings of grandiosity, omnipotence, or inflation of self or abilities
- Risk-taking behaviors based on inflation of self
- Feelings of euphoria or elation
- Disconnected and very fast or racing thoughts
- Difficulty sleeping or an inability to regulate activity, such as staying up all night working on a school project and then staying up to bake chocolate chip cookies
- Loss of appetite
- Weight loss
- Fast speech and increased volume over normal speech patterns
- Increased irritability

Bipolar disorder is usually a lifelong condition. There is no cure, but it can be managed. The preferred treatment for bipolar disorder is a combination of talk therapy and medication, which can help to stabilize mood and avoid the dramatic swings between emotional states. Practices such as meditation, yoga, and hypnosis can also be very beneficial.

What Can I Do?

Every parent who comes to me when their child is suffering says the same thing: “I feel so helpless. What can I do?” My answer is always the same: “You can be there for them.” No matter what kind of emotional or mental health challenge your child is facing, your love, attention, and presence provide powerful medicine. The following sections discuss the most

important things parents can do or work toward doing to help their adolescent who is anxious or depressed.

Self-Awareness

Self-awareness is key to helping your child. Anxiety and depression, like many mental disorders, are passed down through inheritance of acquired characteristics rather than genetically. If you are constantly worried or self-critical and perfectionistic, it is more likely that your children will be anxious and self-critical too. Both Trina and Carl's own fears and worries about pleasing their parents consciously and unconsciously influenced their messaging to Pamela about achievement and success. Jim and Ellen were both children of divorce, and they came to realize they had passed down their feelings of impermanence and instability to their son Andrew. If you suspect you suffer from anxiety or depression, seek help for yourself through individual psychotherapy. You will also be helping your child.

Educate Yourself

Learn as much as you can about the causes and symptoms of anxiety and depression. Be an informed consumer when it comes to treatment. Don't be afraid to question the professionals who are treating your child. Remember that talk therapy takes time, consistency, and continuity to be successful.

Open Your Mind and Your Heart

Be honest with your child about your own behavior and feelings. Listen to what your child has to say without becoming defensive or justifying your actions. Step back emotionally and try to see your behavior from their perspective. We all make mistakes, even when we think we're doing the right thing. It's

hard to accept that you may have a part in the pain your child is experiencing, but that's a big step in helping your child.

Be There

Your physical and emotional presence is as important to your child now as it was when they were younger. This means being available on your child's schedule, learning to read their social cues that tell you they need you, and understanding when they're open to talking. The more time you can spend with them, the more you will see the ebbs and flows of their moods, and the more likely and willing they may be to share the important details of their lives.

Open Communication Is Critical

If you are uncomfortable talking about feelings or make it clear that subjects like drugs, sex, gender, violence, social dynamics, politics, and religion are off-limits, then you cannot expect your child to be honest with you.

Listening without judgment and interjecting your own opinion or concerns is essential, as is reflecting and acknowledging their feelings by using mirroring statements and your facial expression. Instead of telling your child how *they* are feeling—"You're sad," "You're angry," "I understand that you're feeling..."—use phrases like, "You look," "You sound," or "You seem," which articulate *your* perceptions. For instance,

- "That sounds like a terrible experience. I can see that you are very upset."
- "You look awfully tired lately."
- "You sound sad."

- “You don’t seem quite yourself.”
- “I can see that you are sad, and I’m worried about you.”
- “I’ve noticed you’re spending more time alone lately.”
- “I want to help but don’t want to pry. Can you tell me what’s going on?”

Ask specific rather than general questions. For example, instead of asking Pamela, “How was your day?” Trina would ask, “How’s the paper on the Russian Revolution going? I know you were concerned about getting it done on time.” When Andrew had dinner with his father, instead of asking, “How did you do at the baseball tryouts?” he would ask Andrew how he felt about the tryout. If Andrew responded, “Okay,” and left it at that, Jim would ask more specific questions: “Who showed up to practice today? Do you like your position on the field?”

Offer Empathy, Not Advice

The hardest thing for a parent to see and experience is their child in pain. Parents often want to jump in and fix the problem or minimize their child’s emotional pain because their teen’s discomfort makes *them* uncomfortable. You can never go wrong offering affection and empathy, and reflecting your child’s feelings. If you were raised in a family that didn’t talk about feelings or ignored emotional distress, this may be hard for you.

Listen, and let them finish talking before you speak. You can offer to help in a way that allows them to accept or reject your offer rather than imposing your own solution. “I hear how disappointed you were not to be invited to Regan’s party. Do you want to talk about how to tell her that?” This approach gives your teen control over the amount and intensity of your involvement. Telling stories about your own childhood or

sharing instances in which your feelings were similar gives them the power to ask you how you handled a similar situation or feeling. If they reject your advice or support, simply go back to listening and reflecting their emotions.

Like toddlers, adolescents often do not know exactly why they're feeling what they're feeling. It is mostly up to you to help them figure out the connection. Sometimes it's hard for them to tell whether they're reacting to real-world or internal conflicts. It can be useful to use your imagination about the world your child lives in and the stresses they face. I taught Trina and Carl to use the phrase "I wonder" when they tried to understand the origin of their daughter's anxiety: "I wonder if you're not sleeping tonight because you have a math test tomorrow?"

The Power of Touch

Remember when your child was younger? Hugs, snuggles, and cuddles went a long way to soothing them when they were upset, scared, or angry. Since toddlers and adolescents have so much in common, the same nonverbal strategies are as effective now as they were then. Unlike toddlers, your adolescent probably won't climb into your lap, and they may tell you they don't want to be touched at all. You may need to initiate contact, but don't be offended or upset if your child pulls away.

A ten-second hug—if your child will allow it—stimulates the hormone oxytocin, the love hormone, and decreases the stress hormone cortisol.¹⁵ If your child won't tolerate that kind of attention, sitting shoulder to shoulder on the couch watching Netflix or playing video games has much the same effect.

Staying Close to Home

If you know your child is struggling or has struggled with depression or anxiety in the past, the more contact you have with your young adult child, the easier it is to be aware if they are struggling, and the more willing they may be to listen to your concerns about their well-being and seek help. If the child is a minor and living under the same roof, parents who know the signs and symptoms that indicate trouble can intervene before problems escalate. Once children are eighteen and are legally independent adults, they have legal control over their persons, decisions, and actions, even if they live with you.

A sensitive, shy, socially awkward, or anxious child may take longer to separate from you and the family home. It's important for these kids to feel they can come home to the same loving parents and secure space. No matter how impressive their academic achievement, the college environment and proximity to home may be as important as what they study. These kids often need to touch base or emotionally refuel by coming home more often. They may be more comfortable attending a college that's a shorter distance away; even if they don't come home every weekend, knowing that they can is reassuring. If you have a sensitive kid, you may want to consider waiting to turn their room into a gym or home office until after they graduate from college or have been living on their own for a while. I also suggest you discuss your plans with them first, so they're not shocked when they come home for a visit and find out they have to sleep on the foldout couch in the living room.

Accept Your Child

We all want to say we accept our children for who they are, but it is often hard to distinguish what they desire for themselves from what we wish for them. True acceptance is acceptance without imposing our own expectations,

assumptions, and personal bias about our children's identity and life choices. I realize this is often easier said than done, but your child's mental health and your future relationship with them depends on it. Trina and Carl had to learn to accept that Pamela might want to go to a less prestigious college. Other parents struggle with their children's sexual or gender identity, romantic partner, or career choices.

I know that confronting these problems is hard. However, if your child shows signs of anxiety or depression, or any other emotional or mental disorder, the sooner their issues are addressed, the easier it is to treat them. It's important that you get as much professional help for your child as possible. It's also important that *you* and your partner or spouse get the support you need from family and friends, and if you need help or professional guidance, that you get it.

Attitudes toward mental health issues are changing, and mental disorders don't carry the same stigmas as they have in years past. As hard as it may be, creating an open and frank dialogue about what your child is going through is essential. You can treat the situation with embarrassment and shame, or you can create an empathic and nonjudgmental environment in which your child and family can heal. The choice is yours.

[I.](#) See Appendix: "A Note about Psychiatric Medication."

CHAPTER 6

ADHD, LEARNING ISSUES, AND SOCIAL-DEVELOPMENTAL DISORDERS

Parenting an adolescent is hard enough. When you add the challenges of attention-deficit/hyperactivity disorder (ADHD), learning issues, or other social or developmental disorders that can impact behavior, mood, performance in school, and self-esteem, parenting can become exponentially more difficult. Many of these conditions can be addressed and mitigated with proper diagnosis and treatment. Fortunately, these issues are now better understood and less stigmatized, and more support services are widely available.

If your child was diagnosed with any of these conditions before reaching adolescence, you probably already have treatment or support plans (or both) in place. Even if your child has been doing well, however, the hormone surges, emotional turmoil, and social pressures of adolescence can create new or additional challenges. Adolescents are already more self-conscious about differences and not fitting in, and more aware of differences in others. There's more bullying and teasing than in the lower grades. A kid who seemed to be doing fine in fourth grade may begin to struggle both socially and academically in the seventh grade.

If your child hasn't been diagnosed with a learning disorder like dyslexia earlier, it may be because they had learned to

compensate by relying on memorization and concrete ways of doing math. Often dysgraphia, which impacts the ability to write legibly, is missed because kids are writing on computers more than with pen and paper. As more complex and analytical reading skills and comprehension and abstract reasoning in math are required, kids may start to flounder.

Many kids are diagnosed with learning disorders in the ninth or tenth grade, when their compensation mechanisms are no longer sustainable, competition becomes more intense, and they can't keep up with increasing academic and social demands.

Sometimes their problems at school are dismissed by their teachers as laziness or excused with "She's a smart girl, just disorganized." Or, when a parent expresses concern about their son's social awkwardness, a well-meaning relative may say, "He's always been shy. You need to push him to get out more." A pediatrician may wave off concerns with the assurance, "She'll outgrow it." As their parent you are in the unique position of knowing your child better than anyone else and being able to observe your child academically and socially. When you do spot something, this knowledge can make all the difference in your adolescent succeeding or feeling like a failure. Denial that there is something wrong or the wish that behavior or learning issues would go away on their own does not help your child. The earlier you observe, intervene, and help your child to get the proper evaluation and support, the easier it will be to treat their challenges.

The three most common undiagnosed conditions that can affect their long-term mental health are ADHD, learning disabilities, and social and developmental disorders.¹ We now know that these conditions are often connected. All of them can

contribute to social isolation or difficulties and low self-esteem, leaving adolescents vulnerable to depression and anxiety. In many cases, ADHD and social disorders are the result of unrecognized, misunderstood, and untreated anxiety.¹

Attention-Deficit/Hyperactivity Disorder

ADHD is an often misunderstood indication of an emotional regulation issue. It is overdiagnosed, misdiagnosed, and in some cases, missed entirely. If this sounds contradictory, let me explain.

ADHD is a faulty wiring of the limbic or stress-regulating system and involves the brain's reaction to perceived or real threats.² The symptoms of ADHD—difficulty with focus and attention, being forgetful, the inability to sit still or stay seated, impulsiveness—are real.³ But while many people believe ADHD is a biological disorder of the brain, in almost all cases, it is caused by the brain's reaction to stress and is tied to anxiety. It impacts attention, learning, and behavior, including the ability to control one's body and emotions.

There are three subtypes of ADHD:

- *Hyperactivity/impulsive type*, which does not show significant inattention
- *Inattentive type*, which does not show significant hyperactive-impulsive behavior—previously called *attention-deficit disorder* (ADD)
- *Combined type*, which displays both inattentive and hyperactive-impulsive symptoms

The issue isn't that we're not identifying the kids who suffer from ADHD; we don't want to look at the environmental

influences related to stress that are behind the symptoms. There is a biological component to ADHD; some children are born with a sensitivity to stress that makes them more prone to ADHD.⁴ More boys than girls are affected.⁵ In its most severe state, this disorder can disrupt behavior, learning, family dynamics, and a child's ability to be accepted and even loved.

If a child has symptoms of ADHD, it is not inevitable that they will develop ADHD. If root causes such as emotional issues, learning issues, or family dynamics are addressed, then early symptoms may not develop into a full-blown diagnosis. However, if the signs of stress are not addressed and symptoms persist, they become a disorder in itself.

When Pamela's and Ian's son Gideon was in fifth grade, his teacher reported that he seemed to have signs of ADHD or a behavioral problem. His impulsive and sometimes aggressive behavior of pushing or hitting other children during class got him into constant trouble with the teachers. The school recommended that Gideon be evaluated, and Pamela and Ian agreed. They took Gideon to a psychologist who specialized in evaluating kids with similar issues. After several sessions with Gideon, he found that the boy's symptoms and behavior were triggered by the emotional stress he felt over his parents' unhappy marriage. Pamela and Ian were constantly fighting, and both of them regularly threatened the other with divorce. Ian was a functioning alcoholic, and no one outside the family was aware of it. Because Gideon kept these family secrets, neither his friends, teachers, nor the school counselor knew about his home situation. Gideon was both anxious and depressed, the therapist reported to his parents. Pamela and Ian agreed that Gideon should begin psychotherapy twice per week. They entered parent guidance and Ian went into alcohol rehab. Therapy gave Gideon a safe outlet for his intense feelings, and the family received the support they needed to create a more stable and nurturing home. As a result of these interventions Gideon's behavior at school changed without the need for medication.

One in ten kids in the United States is diagnosed with attention-deficit/hyperactivity disorder.⁶ The symptoms for children are the inability to sit for long in the classroom, difficulty staying engaged in any one activity for long, and the need to get up and move their bodies when they are in a social

setting—often (but not always) accompanied by physically and verbally impulsive and aggressive behavior.

In the United States, ADHD is a diagnosis that is too frequently used to describe depression and anxiety in children. Other countries, like France, consider ADHD as a psychosocial disorder and treat the condition by focusing on the underlying cause with psychotherapy and family counseling, an approach with which I strongly agree. This approach takes time and effort on the part of the parents. Far too often, teachers, pediatricians, and parents are quick to medicate away the symptoms rather than deal with the underlying emotional issues. More and more adolescents are being diagnosed, and more of them are being medicated so that they can perform better academically or test more effectively on college entrance exams.⁷

Some children may need medication if their symptoms are extreme but only as a bridge until a mental health professional can pinpoint the underlying emotional stressors causing the symptoms. Medication is not a long-term or permanent solution. Many teens are quickly medicated to silence their emotional pain and to alleviate their symptoms because it's easier for the adults in their lives.

Ritalin and Adderall, both central nervous system stimulants, are the two most frequently prescribed drugs for treating ADHD. There are some cases where medication can be useful in conjunction with psychotherapy for a limited time, particularly if the symptoms are intense or disruptive.⁸ I see talk therapy as a long-term sustainable form of treatment with no unwanted physical side effects; temporary medication can give kids the ability to slow down and absorb the lessons of therapy. I do not believe that medication should ever be used as the sole

treatment for these disorders or used on a long-term basis except in very rare cases.

We all experience fear. Fear itself is not unhealthy; it's kept us alive as a species. Fear kept humans from being attacked and eaten by predators or walking into a bear's den. Like fear, stress itself is normal. It's not stress or fear in the moment that's the issue; it's constant, chronic stress and fear over time.

When the limbic system is stuck in a negative feedback loop, as described in Chapter 3, and hormones like cortisol remain in the body, we feel constantly anxious and on the defensive, even when there's nothing to be afraid of. This state of hypervigilance makes it difficult to do anything else, and focusing for long on any activity or even staying in one place for long feels too frightening. It impacts the ability to learn, to relate to others socially, and to comfort oneself.

If the stress system is always activated, it may become blunted, or *hypovigilant*. When the stress is chronic, the amygdala, working overtime, essentially poisons itself with stress hormones and burns itself out.

Boys' brains are more susceptible to the effects of cortisol and chronic anxiety, which may be why more are diagnosed with ADHD.⁹

Learning Disabilities

We're still not sure exactly what causes learning disabilities (LDs). We do have theories. There may be a genetic connection, which, while it cannot be proven, is implied by the similarity of learning styles and learning challenges among family members.¹⁰ We know that structural brain development issues impact a child's ability to receive, store, process, retrieve, and communicate information. There are neurobiological changes

in the brain that impact cognitive processes related to learning. These processing problems can interfere with learning basic skills such as reading, writing, and math. They can also interfere with higher-level skills such as organization, time planning, abstract reasoning, long- or short-term memory, and attention.^{[11](#)}

There is also thought to be a connection between LDs and injury to the developing brain before or during birth, which can be the result of a mother's serious illness or injury, by her drug or alcohol use during pregnancy, or malnutrition.^{[12](#)} Low birth weight, oxygen deprivation during labor, premature or prolonged labor, exposure to environmental toxins, nutritional deprivation, and ingesting toxic substances like lead paint, alcohol, and tobacco may be contributing factors.^{[13](#)}

What we do know is that LDs are *not* caused by visual, hearing, or motor disabilities; intellectual disabilities; emotional disturbance; cultural factors; limited English proficiency; environmental or economic disadvantages; or school quality.^{[14](#)}

LDs are more common than we think. One in five kids have learning and attention issues and 30 to 50 percent of kids with ADHD symptoms have learning disabilities, many of which are undiagnosed.^{[13](#), [15](#)} If left untreated, LDs can contribute to low self-esteem, depression, anxiety, attentional issues, and behavior problems.

A third of students with an LD have repeated a grade, which increases the risk of dropping out. Nearly two-thirds of special education disciplinary removals involve students with LDs or other health impairments, which is the disability category that covers many students with ADHD. The dropout rate for students with LDs, over 18 percent, is nearly three times the rate of

students without learning disabilities (6.5 percent). Fifty-five percent of young adults with LDs have been involved with the justice system.¹⁵

Most children are diagnosed with LDs when they are in primary school, but some are not identified until adolescence, or even later, as adults.

Most people with LDs are of average or above-average intelligence but have a gap between their potential and actual achievement. Your teen or young adult may hide their disability well or compensate with tricks they have taught themselves throughout early childhood and primary school to cover up their learning difficulties. It is not until academics get harder or more abstract, usually in high school, that many kids show signs of real struggle.

Forty-eight percent of parents believe—incorrectly—that children will outgrow these brain-based difficulties, and 33 percent of educators say that sometimes what people call an LD is really just laziness.¹⁵ Kids with LDs often feel shame, sadness, frustration, anger, guilt, and embarrassment, as well as depression and anxiety.

According to a 2017 report from the National Center for Learning Disabilities, the stigma and low expectations still associated with LDs mean these kids are more likely to repeat a grade, get suspended, and leave high school without a diploma. Low self-esteem and stigma may explain why only one in four students with LDs tell their college they have a disability and why only one in twenty young adults with LDs receives accommodations in the workplace. This is a shame because the Individuals with Disabilities Education Act (IDEA), formerly known as the Education for All Handicapped Children Act, mandates a free and appropriate public school education for all

eligible students ages three to twenty-one. These accommodation services are free, no matter your income level. You'll find more information about IDEA in the Resources (page 248).

It can be hard for parents to accept that their child may need more help and support than they can give them, or is different from other kids, but this should not get in the way of a child being properly diagnosed and treated if they have an LD.

Eric and Stephanie were worried about their son Greg, a high school sophomore. His moodiness and unpredictable outbursts seemed extreme, even for a sixteen-year-old. He ignored his schoolwork and hung out with his friends smoking pot and drinking. When he was at school he was the class clown and distracted his classmates and the teachers. His grades were so poor that his parents were worried he might not graduate from high school. Stephanie suspected that Greg might have a learning disability, but Greg refused to be tested or evaluated. He told them it was a joke at school that every other kid got an accommodation for extra time on the SAT. When they received a phone call from Greg's adviser about his grades and behavior at school, they finally insisted that their son be evaluated by a neuropsychologist. The neuropsychological evaluation confirmed Stephanie's concerns that Greg did have an LD: he struggled with reading comprehension and had trouble hearing and understanding what the teacher said in class. Greg had been able to cover up his challenges by using SparkNotes and cheat sheets instead of reading the books for class, and he could always rely on a friend to explain what he missed in class. This year those techniques no longer worked, and Greg felt totally lost and like a failure.

Eric and Stephanie felt terrible when they realized what their son had been going through but quickly hired a learning issues tutor to help Greg acquire real strategies for reading comprehension and learning. They contacted the school, which agreed to provide accommodations, like allowing Greg to tape his classes so that he could go over them at his own pace, and his teachers offered him one-on-one tutoring. Greg also began seeing a psychotherapist to address the emotional pain he felt. In addition, it became apparent that his self-esteem had suffered a great deal from his learning challenges. He knew he was different from the other kids but did not know how or why. He had been too ashamed to tell his parents or teachers that he was struggling. Greg slowly learned to accept that his disability did not define him. He could succeed by accepting the help he needed to fulfill his potential. He no longer needed to smoke and drink as a way to cope with his depression. Greg still was occasionally the class clown but did not need to use it to cover up his fears of exposure.

Many adolescents like Greg suffer in silence. The very good news is that with the proper education, tutoring, and help, a child with an LD can often perform as well as a child without one. LDs may be diagnosed by a qualified school or education psychologist, or by clinical psychologists and clinical neuropsychologists who are trained and experienced in assessing LDs.

According to the Learning Disability Association of America, the most common learning disabilities are as follows:

Dyscalculia

Dyscalculia affects the ability to understand numbers and learn math. Someone with dyscalculia may not recognize or understand math symbols and may struggle with memorizing and organizing numbers, telling time, or counting.³

Dysgraphia

Dysgraphia affects handwriting ability and fine motor skills. An adolescent with dysgraphia may have illegible handwriting, inconsistent spacing of words or letters, poor spatial planning on paper, poor spelling, and difficulty with composition. They have difficulty thinking and writing at the same time. Because schools now concentrate less on handwriting, and children move to writing on computers (and using spellcheck) earlier, dysgraphia may not be noticed until later grades.¹⁶

Dyslexia

Dyslexia affects reading and related language-based processing skills, including reading fluency, reading comprehension, recall, writing, spelling, and sometimes speech. People with dyslexia may reverse letters when spelling or reading or confuse words that sound alike. They may also have

problems naming objects correctly. It can exist along with other related disorders. Dyslexia is sometimes referred to as a language-based learning disability.³

Oral/Written Language Disorder and Specific Reading Comprehension Deficit

Oral/written language disorder and specific reading comprehension deficit affect the understanding of what is read or of spoken language. Someone with these deficits may have trouble understanding or expressing language in both oral and written forms—trouble understanding the meaning of words—as well as how words are put together to form ideas and how the order of words can change their meaning.¹⁷

Dyspraxia

Dyspraxia impacts muscle control. It causes problems with movement, coordination, language, and speech and can affect learning. Although not technically an LD, someone with dyslexia, dyscalculia, or ADHD may also have dyspraxia.³

Executive Functioning Issues

Executive functioning, though not an LD, is characterized by different patterns of weakness in executive functioning. Problems with planning, organization, strategizing, paying attention to and remembering details, and managing time and space are almost always seen in individuals who have specific learning disabilities or ADHD.¹⁸

Social-Developmental Disorders

Social-developmental disorders can be apparent when adolescents have difficulty interacting with their peers or reading social cues like facial expressions and body language,

and have social anxiety or behave inappropriately in social situations. If these occur, the child may have one of several social-developmental disorders. The most common are autism in one of its forms, including “being on the spectrum,” and nonverbal learning disabilities.³

Autism Spectrum Disorder

Autism spectrum disorder (ASD) is a developmental brain disorder that is thought to originate in utero. Symptoms can range from mild to severe and include challenges with social skills, and include problems with repetitive behaviors, speech, and nonverbal communication. ASD encompasses conditions that had been thought to be separate: autism, Asperger’s syndrome, pervasive developmental disorder not otherwise specified (PDO-NOS), and childhood disintegrative disorder.³

ASD diagnoses are on the rise; we’re not sure why. Some people believe there are environmental factors, but the truth is there is still a great deal of mystery about what causes ASD. According to a 2020 report from the CDC, one in fifty-four children in the United States is diagnosed with an autism spectrum disorder. The same report noted that boys are four times more likely to be diagnosed with autism than girls.

Although autism is often diagnosed by two or three years of age, other ASDs may not be diagnosed until later or even overlooked entirely. Teens with undiagnosed ASD are often socially isolated because of their social “strangeness.” This is not to imply that all teens who are isolated have ASD. Many teens who are socially awkward or isolated may suffer from a nonverbal learning disorder, social anxiety disorder, or depression. While they may exhibit some ASD symptoms, they are not autistic.

According to the *DSM-5*, the symptoms of autism include

- Strange body postures or facial expressions
- Avoidance of eye contact
- Impulsive and inappropriate social behavior
- Not observing normal social distancing and boundaries
- Deficits in understanding language
- Speech delays
- Flat or monotone speech
- Lack of understanding of social cues
- Not engaging with peers
- Intense focus and preoccupation with specific topics
- Problems with two-way conversation
- Repeating words or phrases
- Repetitive movements
- Self-abusive behaviors like head banging
- Social withdrawal

Nonverbal Learning Disabilities

Nonverbal learning disabilities (NVLDs) are usually characterized by a significant discrepancy between higher verbal skills and weaker motor, visual-spatial, and social skills.¹⁹ A teen with a nonverbal learning disability may have trouble interpreting facial expressions or body language and may have poor coordination.

NVLDs have nothing to do with intelligence; intellectually these kids may in fact be ahead of their peers and have excellent vocabularies and reading skills, but they feel anxious

and inadequate when they have to interact with people, even one-on-one or in small groups. They may have difficulty making eye contact.

NVLDs are treated with individual psychotherapy to deal with the feelings that arise from being different and socialization groups to teach how to interact with peers appropriately. Learning specialists can help teens adapt to their challenges and focus on their strengths as well as change their behavior and the way they interact with others.^{[19](#)}

Social Anxiety Disorder

Social anxiety disorder, also called *social phobia*, has many of the same symptoms as NVLD. According to the National Institute of Mental Health (NIMH), social anxiety disorder affects 7 percent of Americans. A teen with social anxiety disorder feels fear or anxiety in all social situations because they worry about being judged, humiliated, embarrassed, or rejected. Their fear gets in the way of engaging in everyday activities, including going to school or work. Some people with social phobia do not have anxiety in social situations but feel physical symptoms of anxiety when they are speaking publicly, performing, or playing sports.^{[3](#)}

Social anxiety disorder usually starts during adolescence. It may not be recognized, and these teens or young adults may be labeled as “shy.” Without treatment, social anxiety disorder can last for many years and sometimes a lifetime and prevent a person from reaching their full potential. Substance abuse may be the result of an undiagnosed and untreated social anxiety disorder; some adolescents use alcohol, marijuana, and/or other substances to self-medicate their symptoms.^{[20](#)}

Social anxiety disorder is diagnosed if the following symptoms persist for more than six months and occur when a teen enters a new social situation, performs at school or work, or is called on in school:³

- Blushes, sweats, trembles, experiences rapid heart rate, or feels “mind going blank”
- Feels nauseated or sick to their stomach
- Rigid body posture, little eye contact, or speaks with an overly soft voice
- Finds it scary and difficult to be with other people, especially strangers, and has a hard time talking to them
- Acts very self-conscious, embarrassed, and awkward in front of others
- Fears excessively that others will judge them
- Stays away from social situations

The treatment for social anxiety disorder is psychotherapy, often a combination of cognitive behavioral therapy (CBT) and psychodynamic psychotherapy. Teens are taught mindfulness training to reprogram their brains when confronted with social events and interactions. Social group therapy can also be useful to help modify reactions to social interactions.

If an adolescent is using or there's concern they may use alcohol or drugs to relieve their symptoms, a psychiatrist may prescribe a nonaddictive antianxiety medication as a temporary measure.

Seventeen-year-old Caleb was an only child. He spent a great deal of time by himself and didn't have many friends. His parents Jan and Ramesh described him as

“sensitive” and not liking changes to his routine. The beginning of each school year was a struggle until he became comfortable with his new schedule.

When he was in grade school, Caleb’s parents asked his pediatrician if Caleb had ASD, but the doctor assured them he didn’t; he didn’t match the classic criteria. He could make eye contact and had no trouble talking or expressing affection to his parents or other relatives. Some of his teachers called him shy, but at home he was anything but shy.

Caleb was awkward and uncomfortable around his peers at school and socially. His teachers said the other kids described him as “strange” or “nerdy.” He often said too much or too little or was overly enthusiastic or aggressive even when other kids weren’t interested in his social advances.

Their son’s differences may have caused Jan and Ramesh more pain than they caused Caleb, but Caleb was aware that he was different from the other kids.

Jan and Ramesh found a psychotherapist for Caleb who diagnosed him with a nonverbal learning disorder. In the safe space of the therapist’s office Caleb was able to talk about how being different felt. The therapist suggested that a socialization group could help Caleb develop more confidence and learn appropriate social behavior. Caleb resisted at first but eventually joined the group and did find it helpful.

Caleb was beginning the process of applying to college. After consulting with Caleb’s therapist, Jan, Ramesh, and Caleb decided a smaller school with more supportive services would be a better fit for him. He wanted to be closer to home so that his parents could visit and he could come home whenever he needed.

If LDs are properly diagnosed, treatment and support programs put in place for them can literally change lives. LDs that are ignored or misdiagnosed can lead to other mental health and behavioral issues. As a parent, you know your child better than anyone, and if you suspect your child may be struggling, don’t wait for others to identify a problem. Seek out help, get an evaluation, and get the proper support for you and your child. It doesn’t matter how old your child is; even adults have been diagnosed with ADHD and NVLD and have improved their lives with the right adaptive strategies and support.

CHAPTER 7

DISORDERED EATING AND EATING DISORDERS

Eating disorders (EDs) lie on a spectrum from disordered eating—overeating, binging, and fasting/calorie restriction for weight loss—which is usually considered mild, to severe—bulimia and anorexia nervosa—which can be life threatening. While most parents think only girls are at risk, according to the National Eating Disorders Association, one in three people with an eating disorder are male. Boys are more likely to develop binge eating disorders while girls are more at risk for bulimia and anorexia nervosa.¹

Today, according to the National Institute of Mental Health, approximately 2.7 percent of adolescents have had some form of an eating disorder; this includes 3.8 percent of girls and 1.5 percent of boys. Those percentages translate to 780,634 young women and girls, and 321,506 young men and boys.² EDs like anorexia and bulimia are on the rise. A Columbia University study reports that the incidence of anorexia in girls ages fifteen to nineteen has increased each decade since 1930. The death rate for EDs is twelve times higher than the death rate of all causes for women between the ages of fifteen and twenty-four.³

Because the reward centers of the brain develop well before the emotional regulation parts can catch up, adolescents are naturally obsessive. It's part of natural development for teens

and young adults to use food as a reward, to assuage painful or unpleasant feelings, or to overindulge. Remember the old ad line about potato chips, “Bet you can’t eat just one”? It might have been written with adolescents in mind.

All eating disorders should be taken seriously, as it’s not unusual for what begins as a relatively mild case of disordered eating, like unnecessary dieting or unusual food restrictions, to escalate if underlying psychological and emotional issues are ignored. Eating disorders are secretive conditions, and the signs and symptoms are easy to overlook. All eating disorders can significantly impact a person’s health by interfering with the body’s ability to get adequate nutrition. Long-term effects include harm to the digestive system, heart, bones, and teeth.⁴

All eating disorders share some common elements: a preoccupation with weight, body image, and body shape, and viewing food as a nemesis. They have their psychological and emotional roots in the early childhood development of the parts of the brain responsible for emotional security and resilience to stress. A highly active amygdala makes teens, particularly girls, self-conscious and preoccupied with body image. Eating disorders have also become associated with cultural and social stressors such as changing beauty standards and the desire for peer acceptance.

It is a common myth that eating disorders are always about self-destructive behavior. Eating disorders begin as ways to comfort, soothe, and protect oneself; they are a way to cope with pain that gets out of hand. For some they are a means to control the uncontrollable: sexual maturity or even a parent’s overinvolvement or lack of involvement in their lives.

Eating disorders can develop at different times in one’s life, but the majority emerge in the teens and early twenties.

Physical Versus Emotional Hunger

Food serves many purposes. It can provide us with energy and nutrition, which is connected to physical hunger. It is one of our first experiences of connection, love, and comfort, and can also be used to meet emotional needs, which is referred to as *emotional hunger*.

Food and eating behaviors only become problems when they are no longer used to satiate physical hunger but to meet emotional or psychological needs instead. At one time or another we've all probably worried about our weight and what we're eating: 45 million Americans go on a diet each year, and 75 percent of women feel embarrassed by their body size and shape.⁵ ⁶ However, when how much and what kind of food we're eating become central to our thinking and how we're living, or the focus on what we weigh has replaced or usurped a focus on relationships and activities, it becomes a serious problem that has to be addressed.

Food is often given as a reward, such as, "Let's have ice cream to celebrate that A in math," or a bribe, "If you clean your room, we'll have pizza for dinner." It is offered in place of love or attention, such as, "Here's a piece of candy, now stop crying!" Withholding food can also be used as a punishment. This creates an association between behavior, comfort, security, and food: "Do what I want and you will get a treat; misbehave and I will take food away."

Adolescence is full of *feeling*. Food can be used to repress, escape, or numb uncomfortable and painful emotions such as sadness, depression, conscious or unconscious anger, loneliness, fear, vulnerability, anxiety, feeling overwhelmed, and harsh self-criticism. Teens and young adults with an eating disorder use food to self-soothe or self-medicate in the same way that

others turn to drugs or alcohol. In fact, it's quite common for people with EDs to have other obsessive behaviors and addictions, such as drugs, alcohol, sex, or tech simultaneously.⁷

Food can be used as a replacement for human contact or connection. Loneliness and boredom, which are closely related to feelings of loss and abandonment, are commonly connected to behaviors like mindless eating (stuffing your face without tasting what you're eating or enjoying the experience) and eating disorders.

Food can also be used to gain control, independence, autonomy, and power. From the moment a baby throws food on the floor, they are making a statement about their burgeoning autonomy or developing self. When a mother accepts a child's right to regulate their own hunger, that child develops a healthy sense of trust in their own appetite and by extension in themselves. However, when food becomes a power struggle between mother and child, food gains symbolic power as a weapon.

When they're in middle and high school, an adolescent's school and extracurricular activities and social life often mean that a parent isn't involved in the deciding of what and when they eat. If they are away at college or living on their own, those decisions are entirely in the adolescent's hands. Even so, food is still fraught with emotional weight. Having power over food can fool a teen or young adult into thinking they have power over their feelings or relationships that they cannot in fact control. Adolescents who feel like their parents are too strict or controlling will often use food this way. They may refuse food or choose to eat foods they know their parents will disapprove of, or they may deliberately overeat.

Adolescents live in a binary world: they are either A students or failures, either amazing at music or sports or they suck, either popular or losers. They cannot see the gray areas between extremes, such as *I have a wonderful body, and it is mine and it is not perfect but still beautiful*. Adolescents have a harsh internal critic that is constantly assessing and judging. Though they may seem fine to their parents and the outside world, they may still be struggling with how they feel about themselves inside even if they are doing well in school and socially. This disparity between external appearance and internal reality is particularly evident in adolescents with bulimia.

Girls at an early age are often taught by society and by their parents to be mild mannered, compliant, obedient, and well behaved, and that feelings of anger, rage, frustration, or desire are not okay. Being loved is contingent on their being “good.” They’re often afraid of their own aggressive or angry feelings or of being accused of wanting too much. This includes wanting sex. Censoring or repressing these feeling is commonly associated with EDs.

Boundaries are the key to healthy relationships. The role of a parent requires that we not use our children as friends or confidants. They are not put on earth to take care of us; rather we brought them here so we could take care of them. Poor boundaries between parents and children are a major risk factor in EDs. Poor boundaries are present when

- Parents see their children as extensions of themselves rather than as individuals with their own needs and desires.

- Parents do not have healthy boundaries around sexual behavior. They walk around the house naked or make inappropriate comments about their own sexuality or their children's.
- Parents are too permissive or too strict.
- Parents treat their children as their best friend or significant other, either sleeping with their child after toddlerhood or discussing inappropriate adult content with them.

What Causes EDs?

Eating disorders, like other addictions, are one way that adolescents express existing issues. They are practiced in secret and veiled in shame, guilt, and self-rejection. Many people misunderstand the relationship between EDs and mental illness. EDs are not stand-alone conditions. There has to be an underlying disorder like depression, anxiety, obsessive-compulsive disorder, or narcissistic or borderline personality disorder for an adolescent to develop an ED.⁸ EDs can also exacerbate an existing mental health condition. Other risk factors include

- A genetic predisposition to stress, or sensitivity to stress of any kind
- Emotional security and self-esteem issues
- A family history of eating disorders
- Dieting with extreme calorie restriction, which impacts brain development and influences mood, appetite, anxiety levels, and clarity of thought and judgment; what starts out as a habit can become a lifestyle

- Stress or any environmental adversity including moving, going to college and leaving home, getting a new job, and any breakups or relationship conflicts or losses, including a divorce, parental abuse, or neglect

Social and Cultural Factors

Every culture has different ideals of beauty. In some societies, lush curves and extra weight are admired. In the United States, however, the emphasis is on a slim, athletic body, and this often unrealistic standard is reinforced by mass media and social media.

A culture of dieting can contribute to EDs, and unfortunately dieting is a U.S. national pastime. Even though size acceptance and body positivity are growing, dieting is also big business. In 2018, the weight loss business grew from \$69.8 billion to \$72.7 billion and is projected to grow by 2.6 percent every year through 2023.^{[9](#)}

Because many diets require that we ignore our physical cues for hunger or restrict the kinds of foods we eat, they promote feelings of deprivation. Diets do not work long term; more than 95 percent of women dieters end up gaining more weight than they lost.^{[10](#)}

Dieting is a disorder in itself. We all have a natural set-point weight that is determined genetically. Most diets fail because our body attempts to return to its natural set point and, when deprived of food, adapts by using fewer calories to maintain the same weight. Dieters are often alienated from physical hunger and also from feeling satisfied, which causes them to eat more. The cycle of restricting food and relaxing those restrictions means a dieter's weight often yo-yos, encouraging a cycle of literal feast or famine. Extreme dieting can result in vitamin

and mineral deficiencies, altered metabolism, even infertility and premature bone loss.^{[11](#), [12](#)}

Dieting promises relief from shame and anxiety, among other “bad” feelings, but it breeds failure and undermines trust in the ability to feed oneself. It teaches us that physical hunger, like emotional need, is not something to be listened to but rather something to be scorned and controlled. Dieting cannot subdue longing; it can only suppress it. It’s natural for the body to rebel against this kind of restriction of natural appetites by binging.

Family

The most powerful contributors to EDs are family relationships and values. EDs are disorders of the self. When a child does not develop a healthy sense of themselves at an early age, it can put them at risk for an eating disorder or other addictions. The development of the self or self-esteem begins when a child is born. When a child’s needs for nurturing, love, understanding, and attunement are met by her parents and when she feels known and seen, then a baby learns that her emotional needs are acceptable and good, and she develops a healthy sense of who she is and what she deserves. If those needs are ignored or a child is made to feel badly about them, she may always struggle with feelings of inadequacy and internalize that need or feel that being dependent is bad.^{[13](#)}

Children are sensitive to their parents’ sense of self. A mother’s body image and sense of who she is—positive or negative—is internalized by her child.^{[14](#)} If a mother is secure in herself and how she looks, her child is more likely to be comfortable in her own skin. If she is insecure and anxious about her appearance, her child might also adopt that attitude.

Children learn by watching and modeling their parents' behavior. If a parent constantly discusses and monitors their weight and talks about what they can or cannot eat, or if they see exercise as a method of weight control, they may have an eating issue. This can put their child at risk for similar issues.

The three most common forms of eating disorders are

- Binge eating disorder (BED)
- Bulimia nervosa, often called bulimia
- Anorexia nervosa

Binge Eating Disorder (BED)

Binge eating or compulsive overeating disorder is characterized by loss of control over consuming food. It is the most common eating disorder in the United States and can be treated successfully with psychotherapy and behavior modification therapy.

People who suffer from BED eat a large amount of high-calorie food in a short amount of time, even if they're not hungry.¹⁵ They don't stop eating, even if they're uncomfortably full. Their binges are followed by feelings of guilt and shame about their behavior and the consequent weight gain. People with this disorder often see extreme dieting as a solution, but it is not sustainable. When they cannot stay on the diet, they become depressed and return to compulsive eating as a way to deal with their feelings, starting the cycle again.

Depression and anxiety are closely tied to binge eating disorder; they are the root cause and the result. Emotional distress and stress, either external or internal, are often triggers

for BED. Binge eating is a symptom or signal that a person may not be getting what they need emotionally. Some people believe that binge eaters lack willpower or discipline. This is false. People binge because they are trying to fill an emotional void or are using food to soothe themselves. They binge because they have been deprived of affection and support from others, and they struggle to feel valuable and worthy of love. After a binge they may accuse themselves of being greedy, selfish, needy, dependent, and weak.

BED can lead to obesity, type 2 diabetes, and high cholesterol.¹⁶ However, a person with BED may or may not be obese. The two conditions are not the same. BED is a psychological disorder. Obesity is a physical condition in which a person carries so much excess body fat that it becomes a threat to their health.

It's sometimes difficult to distinguish the symptoms of BED from the often remarkable amounts of food teens and young adults (boys in particular) can consume, especially if they aren't overweight. However, there are some common signs or symptoms of BED:

- Eating large amounts of food in an extremely short period of time
- Eating alone or in secret, evidenced by missing food
- Eating little in the presence of others while still gaining weight
- Feeling distressed, ashamed, or guilty about eating
- Frequent dieting without weight loss
- Going from one diet to the next

- Restricting activities because they're embarrassed about their weight
- Weight-related fatigue or high blood pressure
- Eating, eating habits, and weight become the focus of their lives

Bulimia Nervosa

People with bulimia nervosa (bulimia) eat large amounts of food, often in secret, and then purge by inducing vomiting or using large amounts of laxatives or enemas, or they alternate bouts of eating with periods of fasting, strict dieting, or intense exercise.¹⁵ They may also abuse diet pills or supplements. Like BED, bulimia is often triggered by emotional distress and stress, either from external sources or self-imposed.

Bulimia can range from mild or severe. In a mild case, a person may occasionally binge and purge in response to a specific stressful situation. In a more serious case, bingeing and purging could occur daily. In the most serious cases, a teen might induce themselves to vomit up to thirty times a day. Milder cases of bulimia can usually be treated on an outpatient basis with psychotherapy and behavior modification therapy. Sometimes medication is used in conjunction with therapy. Severe cases may require hospitalization.

It can be hard to determine whether an adolescent has bulimia because bulimics are often normal weight, or just a little overweight. Bulimics are often high achievers, perfectionists, and self-critical. They are preoccupied with their weight and body shape, and how they look. Their self-worth is tied to their appearance, and they worry about being or appearing fat, regardless of how much they weigh. They often

appear to be functioning well in school and socially, which is why more subtle signs of the disorder may be overlooked.

Bulimics binge and purge secretly but unconsciously want to be noticed and found. They leave clues—an unflushed toilet, not running water to cover up sounds of vomiting. A bulimic may become defensive and deny having a problem when confronted, but they also want to be found out and ultimately will be grateful. This unconscious desire for help is one of the reasons bulimia can be treated successfully with psychotherapy and behavior modification therapy.

Samantha became a single mom by choice in her early forties. She had always been concerned with her weight and was prone to binge eating when she was anxious or tired. She often commented on her body or those she saw in magazines to her daughter, Candace.

By the time she was thirteen, Candace was very self-conscious about her body. She had always been a little overweight and complained about how she was not thin like the other girls at school.

Samantha noticed that her daughter was moody, apathetic, and always tired. Candace would go between eating very little for dinner to eating two and three helpings. On several occasions Samantha found her daughter bingeing on an entire package of cookies. Candace would disappear into the bathroom immediately after dinner for long periods of time, and when she left the bathroom always smelled of room freshener and the hand towels would be missing. When Samantha found vomit-stained hand towels stuffed into the bottom of the hamper she became worried. She searched Candace's room and when she found laxatives hidden in her daughter's underwear drawer, she decided to call the pediatrician.

Candace protested seeing the doctor, but Samantha insisted. After she examined Candace, the doctor spoke with Samantha alone. Candace was dehydrated, she told her, had a raw throat, and had lost quite a bit of weight since the last visit. Combined with what Samantha had already shared, she believed that Candace could have an eating disorder, probably bulimia.

In addition to a therapist who specialized in adolescent eating disorders, I recommended that Candace see a nutritionist to help her learn to eat to fuel her body and to satisfy her physical, not her emotional, hunger.

Samantha told me that she had always had difficulty feeling connected in relationships and had never found the "right" partner. She had become pregnant deliberately, with no thought of involving the biological father. When Candace was born, she found caring for her on her own was much harder than she could have imagined. Candace was a sensitive baby who clung to her mother. Samantha had to return to work when her daughter was four months old. When she was home, Samantha felt smothered by her daughter's constant need for attention and was bored playing with her daughter for long periods of time. Candace felt her mother's

emotional absence. Eating became her way of filling her loneliness, as it had been for her mother.

Mother and daughter both got the attention and nurturing they needed in therapy and were able to forge a stronger connection to each other. Samantha made more time to spend with Candace. Candace began opening up about her difficulty making friends at school, and Samantha shared her own experiences growing up. Candace even asked her mom for advice about how to handle some mean girls who seemed to go out of their way to tease her.

Treatment was a long haul for Candace, with therapy and nutritional counseling twice per week, but she got through it with her mom's help and support, and went on to lead a normal, healthy adolescent life.

If an adolescent is not an athlete in training, an unusually demanding exercise routine or compulsive exercising can also be a sign of bulimia.

Bulimia is associated with both short- and long-term health risks, including ulcers, tooth decay, gum disease, low blood pressure, and fatigue. In severe cases, there can be permanent consequences: damage to the gastrointestinal tract, kidney damage, a weakened heart muscle, and arrhythmias.

Bulimia shares the symptoms of BED, as well as:

- Excessive focus on eating fatty or sweet foods
- Spending long periods of time in the bathroom, especially soon after meals
- Extreme dieting following a big meal
- Avoiding social contact around eating or restaurants
- Use of bathroom deodorants or mouth sprays after leaving bathroom
- Excessive interest in preparing food but not eating it and avoiding eating with family
- Persistent worry or complaining about being fat and the need for approval from others about their appearance

- Acid reflux disorder and intestinal distress and irritation from laxative abuse
- Chronically inflamed and sore throat, swollen salivary glands, or broken blood vessels in and under the eyes
- Frequent weight fluctuation, often within a ten- to fifteen-pound range

The doctor or dentist may also notice:

- Dehydration
- Electrolyte imbalance (too high or too low levels of sodium, calcium, potassium, and other minerals)
- Increased occurrence of tooth decay, loss of tooth enamel, or cavities and gum erosion

Anorexia Nervosa

I met Linda and Pierre when they contacted me for help with their daughter Heidi. At fourteen, she had recently been diagnosed with anorexia nervosa. Heidi had always been a shy child, her mother told me. She had cried very little as a baby and her parents thought they were fortunate to have such an “easy” child.

Heidi’s parents were a little concerned as she got older. It seemed like she mentally distanced herself from other people when she was stressed and had trouble connecting with other kids her age. She was uncomfortable in social situations and told her parents that no one liked her.

Linda and Pierre had always had a turbulent marriage, and as Heidi and her younger brother grew older, things did not improve. They fought constantly. The kids had all their physical needs taken care of, but neither parent paid much attention to them as long as they were doing well in school and didn’t get into trouble.

It wasn’t until Linda realized that her daughter was obviously and rapidly losing weight that she became concerned. When she mentioned this to Heidi, the girl reacted angrily and told her mother she was fine. At their rare dinners together, Linda noticed that her daughter would move her food around but wasn’t actually eating; she would take her dinner back to her room and say she would eat it later. She always returned a clean plate and silverware to the kitchen before she went to bed.

One day Linda went into Heidi’s closet to retrieve a sweater her daughter had borrowed. Bothered by the smell coming from the pile of dirty clothes on the floor of the closet she picked up the pile to put it in the wash. Underneath were a dozen plastic storage bags filled with food. Heidi returned from school to find her mother

removing the bags from her closet. She started screaming that her mother was invading her privacy, pushed her out of the room, and shut the door. That's when Linda called me.

Linda made an appointment for Heidi to see her pediatrician who could determine whether her extreme calorie restriction had damaged her physical health. Though she was quite underweight, she hadn't suffered any other physical damage. Heidi denied she had an eating issue but at five-feet-six and ninety-eight pounds, she still thought she wasn't thin enough. Her denial of an eating issue and body dysmorphia, or distorted body image, were common features of anorexia nervosa.

Linda and Pierre agreed to work together to do what was best for Heidi. I explained to them that there was so much that Heidi felt was out of her control in her life. The only thing she *could* control was her body, and that's what she did.

Heidi resisted going into treatment, but with the help of her pediatrician, whom Heidi liked and trusted, Linda and Pierre persuaded their daughter to enter an inpatient program. At first she begged her parents to let her come home, but they stood firm. After three months, she transitioned to outpatient treatment. She saw a therapist three times a week and attended an afterschool program where she ate meals with a group of her peers while receiving group therapy.

Heidi had to be readmitted to a hospital after she refused to continue seeing her outpatient therapist and reverted to her pattern of self-starvation. When she was once again stabilized and released, she found a new therapist who was a better fit. It took three years, but she was eventually able to resume a normal life.

Anorexia nervosa, or anorexia, is by far the most serious eating disorder. It is essentially self-starvation and excessive weight loss, sometimes to the point of irreversible physical damage or death.¹⁵ Adolescents with anorexia often require not only medication and psychotherapy but mandatory inpatient treatment. It is not uncommon for anorexic patients to experience many hospitalizations before recovery.

Like people with bulimia, those who suffer from anorexia are perfectionists. They are often insecure about how they perform in school, sports, and social situations, regardless of their actual achievement. They are harshly self-critical and unforgiving of their own frailties and mistakes. Their self-worth is fragile, and they often depend on validation from others. In the throes of the disease, self-worth is tied to what and how much they did or did not eat. Most sufferers are young women, but an increasing number of young men are being diagnosed.

People with anorexia have an abnormally low body weight, distorted body image, and an irrational terror of even the smallest weight gain. They use stringent calorie restriction (not just dieting), excessive exercise, and laxatives, diet pills, and vomiting to maintain what they see as their ideal weight. They see themselves as “fat,” even when those around them see them as emaciated and quite literally wasting away. Even when they are made aware that their condition could result in infertility, heart or brain damage, or multiorgan failure and possibly death, it is extremely difficult to break the cycle of behavior.

People with anorexia are very good at hiding their disorder. The extreme weight loss typical of anorexia is a late symptom. By the time a parent notices, an adolescent has often established what is essentially an anorexic lifestyle. Even in the late stages of the disease, when under a doctor’s care, anorexics will go to great lengths to disguise their extreme weight loss, dressing in loose clothes or layers. They may drink a lot of water or weight their clothes with stones before a weigh-in to try to fool the scale.

Earlier signs that a teen or young adult may have anorexia include

- A relentless pursuit of thinness and unwillingness to maintain a normal healthy weight
- Intense fear of gaining weight
- Skipping meals or making excuses for not eating
- Preparing food for others but refusing to eat
- Odd and/or repetitive food rituals, such as counting bites of food, cutting food into tiny pieces, or restricting the type of food eaten

- Frequent checking in the mirror to look at body flaws
- Withdrawal from normal social activities
- Loss of menstrual period (in women)
- Dizziness and fainting
- Paleness

Later symptoms parents may see include

- Brittle hair and nails
- Dry and yellowish skin
- Severe constipation
- Low blood pressure and slow pulse
- Feeling cold even in warm weather, which is caused by a drop in internal body temperature
- Lethargy or feeling tired all the time

In still later stages of the disease there may be

- Thinning of the bones (osteopenia or osteoporosis)
- Anemia and muscle wasting and weakness
- Growth of fine hair all over the body (lanugo)

Orthorexia

Orthorexia is a lesser-known eating disorder characterized by a focus on “healthy” foods and eating.^{[17](#)} In the last several years I’ve been seeing more and more orthorexia in my practice. While many people living with this condition may start out focusing on healthy eating, it can quickly escalate to

cutting out entire food groups. Someone may start by eliminating meat, then gradually eliminating sugar, fats, and dairy. They label foods “good” or “bad.” Their rules about what they can and cannot eat begin to impact lifestyle and social activities just as other eating disorders commonly do. Their restricted diet can lead to malnutrition, which can result in extreme weight loss, even though it may be unintentional. Symptoms of healthy eating gone wrong include

- Obsession or fixation over healthy foods and eating
- Inflexible eating habits
- Severe emotional turmoil, depression, or anxiety if rules of eating are broken
- Cutting out entire food groups, such as meat, animal products, sugar, fats, gluten
- Constant worry about sickness or illness
- Focusing on “good” and “bad” foods to the point of obsession
- Skipping social events to avoid certain foods

What Parents Can Do to Prevent Eating Disorders

The best way to treat an eating disorder is to prevent one. This starts with you and what your children have learned from you about food.

Eating disorders are of course related to body image and eating habits, but more important, they are related to feelings of self-worth. Your own self-awareness is the key to healthy eating habits in your children. I’ve said it before: children model their parents’ behavior. If you disparage your body or

your child's body, weigh yourself constantly and obsess about what and how much you eat, or diet constantly, your children will adopt those attitudes. Appreciate your child's body and your own body. Talk honestly about what you like about your body as well as how you accept the parts you do not like as much because you love your body as a whole. Talking about how different body shapes are beautiful and not criticizing other bodies as fat or unattractive help cultivate and reinforce body positivity. Be careful of using the mirror or scale as a measure of self-worth.

Talking about your child's body or weight in front of them without their permission is humiliating to your child. If you have concerns about your child's eating habits or body weight, speak to their doctor privately and let the doctor initiate a conversation with your child.

If food is treated as a punishment or reward, or mealtimes become a test of wills about what and how much a child "should" eat, that child will no longer associate eating with pleasure.

Offering young children healthy food—food that nourishes the body—and letting them eat as much or as little of it as they want teaches them to trust their own hunger and how much they really need to be satisfied. As they get older they will be less likely to use food to deal with their feelings.

Satiation isn't just a physical experience: the feeling of being physically full reflects the feeling of having emotional needs met. Dieting is about physical and emotional deprivation. Teaching your child an antideprivation approach to eating can help prevent them from developing an ED.

To teach your child an antideprivation approach to eating, keep a wide variety of foods available in the house. There are

no forbidden foods. Trust me, if you don't keep their favorite fattening food around, they'll still get it somewhere else.

If You Think Your Child Has an Eating Disorder

If you think your child may be developing or may have an eating disorder, it's important that you speak to them about your concerns.

I understand that this is not an easy thing to do. It may be one of the most serious and difficult conversations you have with your child and should be approached with love, respect, and sensitivity. The goal of the conversation is to express your concerns, make your child aware of the behavior you've observed, and get them to talk to you and finally accept professional help. You may be confused about how to do this and not alienate your child or drive them away. I hope the following information and suggestions help.

If your child is under eighteen, begin by speaking with your child's doctor about your observations; they may be able to allay or confirm your fears. It can also be helpful to speak to a therapist who specializes in treating children and adolescents with eating issues.

Even if your child is legally an adult, you are still their parent. You have an obligation to express your concern and help your child get help if you can. No matter how old your child is, the suggestions that follow apply.

Find a time to talk when you won't be interrupted and you're feeling calm.

Keep in mind three things you will need to communicate: what your concerns are, how you feel, and what you would like the outcome of the discussion to be.

Prepare what you want to say in advance and write it down. I suggest you begin by stating how hard this is for you. Be specific about why you have come to suspect a problem. Using language like “You have to quit,” or “I know how you feel,” are conversation stoppers when your goal is to get your child to open up to you. Use “I” statements that focus on your own feelings and experience of what you see: “I have been worried because I see [the specific behavior].” Express your concerns about their health and welfare and how difficult it is to suffer alone with a problem.

Don’t be surprised if your child becomes defensive and denies that they have a problem. The majority of teens with EDs deny that they need help.¹⁸ They may become angry (How dare you!), accuse you of attacking them (It’s my body!), or attack you by bringing up unrelated issues (You always try to control me!). Try not to become angry and defensive yourself; state your observations and concerns calmly. Offer your help in finding a suitable professional for them to speak with. If they resist, you could suggest they talk to their pediatrician.

If you feel your child is becoming too upset, end the conversation. There is always a chance that your conclusions are wrong, but if you see the behaviors continue, open the conversation again. If you see visible changes to their health and they are under eighteen, speak to your child’s doctor about how to intervene. If your child is over eighteen, there are still ways you can help and support them. Please see the Resources section at the end of the book.

Treating Eating Disorders

All eating disorders should be treated. The earlier treatment begins, the better the chances of a full recovery. In cases of

severe bulimia and anorexia, early treatment can help avoid long-term medical complications, and in some cases can mean the difference between life and death.^{[18](#)}

Treatment for EDs varies according to the diagnosis and severity of the disorder. Some disorders—BED and mild to moderate forms of bulimia—can be treated outside a hospital; others, like severe cases of bulimia and many cases of anorexia, require hospitalization. In some cases, hospitalization may be followed by a residential program until a child's weight and emotional state are stable, in addition to further outpatient psychotherapy and medication.

Treatment plans are tailored to the individual and may include one or more of the following:

- Psychotherapy
- Support groups, like Eating Disorders Anonymous (EDA)
- Medical care and monitoring
- Nutritional counseling
- Medications

Psychotherapy—talk therapy—can be done on an individual, group, or family basis. Different approaches are used for different conditions. For example, a family-based therapy called the Maudsley approach, where parents of adolescents with anorexia nervosa assume responsibility for feeding their child, appears to be very effective in helping people gain weight and improve eating habits and moods. Cognitive behavioral therapy (CBT), a type of psychotherapy that helps a person learn how to identify distorted or unhelpful thinking patterns and recognize and change inaccurate beliefs, helps to reduce or eliminate

binge eating and purging behaviors. Sometimes talk psychotherapy and CBT are used together.

Studies also suggest that medications such as antidepressants, antipsychotics, or mood stabilizers may be helpful for treating eating disorders and underlying anxiety or depression. They are used in conjunction with other therapies; they cannot “cure” EDs when used alone. Medication should be prescribed by a psychiatrist who has experience working with adolescents with eating disorders.

If your child has an eating disorder, courage and early intervention are necessary to help them. Trust your instincts and don't ignore behaviors that you feel are worrisome. Your child's long-term mental and physical health may depend on it. In the Appendix, you will find a list of websites and organizations that can provide you with information and support on your child's journey to healing.

CHAPTER 8

DRUGS, ALCOHOL, AND VAPING

Almost all teens experiment with drugs, alcohol, and vaping. Pushing boundaries and disregarding the possible consequences is normal adolescent behavior, no matter how upsetting it may be. You did it. I did it. Your child will probably test those waters, even if they don't say anything to you about it.

Sometimes experimentation turns into abuse or addiction. Unlike experimentation, which comes and goes, addiction spirals quickly into behaviors that are out of your teen's control.

Let's face the facts: teen drug and alcohol use is not a rarely occurring problem. According to the National Institute of Drug Abuse, 82 percent of high school seniors have tried alcohol, with 28 percent of those seniors reporting binge drinking within the last two weeks of the survey. Illegal drug use is also disturbingly common and increases as teens grow older; 8 percent of eighth graders report using illegal drugs within the last month, while 22 percent of twelfth graders do. Even more concerning is the fact that as many as 23 percent of young people in the United States end up meeting the diagnostic criteria for substance use disorders by the age of twenty.¹

While smoking cigarettes has decreased, it's still an issue: according to the 2018 National Survey on Drug Use and Health, roughly 47 million people over the age of twelve reported they smoke cigarettes daily. More worrisome is the fact that teens

are turning to vaping in record numbers. The Centers for Disease Control and Prevention reported that the high schoolers and middle schoolers who reported they had tried vaping or were vaping regularly increased by 78 percent and 48 percent, respectively, from 2017 to 2018. A study by Truth Initiative and the CDC reported that the amount of nicotine in e-cigarettes, such as JUUL, more than doubled between 2013 and 2018. Contributing to the popularity of vaping are the options for different flavors, from bubblegum and cotton candy to mint. This marketing tool has targeted adolescents and teenagers, making vaping even more attractive to them, and ultimately placing them at a higher risk for addiction.

Vaping is not just dangerous because of the nicotine, which is highly addictive. E-cigarette or Vaping Product-Use Associated Lung Injury (EVALI) is a disease that can have fatal and long-term health consequences, including lung damage, seizures, and a higher risk of heart attack and stroke.² A Stanford University report showed that teens and young adults who vaped are five to seven times more likely to test positive for the COVID-19 virus. Black market cartridges often contain THC (the psychoactive component of marijuana) and have been linked to serious lung injuries.² This is because knock-off cartridges are likely to be adulterated, and you never know what you are getting.

Drug and Alcohol Addiction Is a Disease

Drug and/or alcohol addiction is a substance use disorder (SUD). This is a psychiatric disorder that impacts brain development and functioning as well as behavior and is characterized by the inability to control use of a substance.³ For years there was a distinction in the *DSM* between physical

dependency and addiction. In the 1980s the *DSM* removed that distinction and rolled it into one diagnosis: SUD.⁴

Addictive drugs like nicotine, heroin, methamphetamines, cocaine, or alcohol impact the pleasure centers of the brain by repeated stimulation of the reward center. Chronic drug and alcohol use can create physical and psychological dependency that leads to withdrawal symptoms and cravings, which lead to more drug abuse. Dependency is a physical need for the substance that is marked by the need for more drugs or alcohol to get the same effect and withdrawal symptoms when someone no longer uses it. These drugs make the user feel good in the moment and are characterized by how bad they make users feel when the effects have worn off.

Addictions are an attempt to fill a void where emotional security and the ability to self-regulate emotions should reside. They are an attempt by adolescents to self-soothe or self-medicate and manage anxiety, depression, and painful feelings due to loss, trauma, or emotional insecurity.

In rare cases, an adolescent who is prescribed drugs, usually opioids, for pain from an injury can become physically dependent on them. This dependency can evolve into both a physical and psychological addiction, and needs to be treated by medical professionals.

All in the Family

Addiction is more common among teens who have experienced abuse, neglect, environmental stress, or poverty. However, the incidence of teens with addictions to alcohol, drugs, and vaping who come from affluent backgrounds where *obvious* abuse or neglect is not present is rising. According to a 2009 study, the three main factors that contribute to teen

substance abuse include emotional sensitivity, a period of vulnerability when they're more affected by stress, and the normal developmental process of adolescence.

Childhood adversity, trauma, or loss may not always be obvious, even to parents or those closest to a child. Some adolescents may suffer from attachment disorders from early on in development; some may be affected by the impact of divorce, an ill health or family illness, family financial stress, an emotionally fragile parent, emotional neglect, or abuse. Rejection by peers or social or academic challenges, or even too many changes and transitions—like moving too frequently or changing schools constantly—may be traumatic to a teen who is sensitive to change. Although these issues may have a powerful impact on their child, parents with the best of intentions may overlook many of these losses as insignificant. Childhood adversity, trauma, or loss increased the risk of drug abuse by 50 percent, depression by 54 percent, alcoholism by 65 percent, attempted suicide by 67 percent, and intravenous drug use by 78 percent.^{5, 6}

There is often a genetic component to sensitivity to stress, depression, and anxiety that can make a child more vulnerable to addictions. As I mentioned in Chapter 1, many children are born with a short allele on their serotonin receptor that makes them more susceptible to stress of any kind.

There is also a strong connection between addiction and the inheritance of acquired characteristics. These are traits or behaviors passed down from one generation to the next through experiencing and observing parental behavior. Children can sense and are vulnerable to their parents' emotional challenges. For example, if a parent has an addiction to alcohol or prescription painkillers, a child may learn that is

the way to cope with stress and emotional distress. If a family member suffers from a drug or alcohol abuse issue, it's more likely children in that family will also.

Stress and Addiction

Family stress is just one kind of stress that may make adolescents more susceptible to drug and alcohol use and addiction. Other types of stress include social rejection, health issues, learning or academic issues, physical differences like being extra tall or extra short, or being very skinny or obese—anything that makes them stick out from their friends, schoolmates, or coworkers.

According to a Yale study, stress is directly connected to alcohol and drug abuse. Other studies show that earlier stressors are more inclined to be connected to amphetamine use and later stressors to heroin use.[7](#), [8](#)

If an adolescent has a substance abuse issue, it's likely that they've suffered with stress in the past; may have been the victim of physical, emotional, or sexual abuse; or are coping with stress in the present.[9](#) It is also highly likely that they're suffering from undiagnosed anxiety, depression, or a conduct disorder (defined as socially unacceptable or aggressive behavior and often a lack of remorse).[10](#), [11](#)

If It Feels Good, They'll Probably Do It

Teens and young adults are thrill seekers. Coupled with their impulsiveness and less than stellar judgment about future consequences, teens and young adults are more likely to indulge in risky behavior, which includes experimenting with and abusing drugs and alcohol.

Teen brains are also uniquely vulnerable to developing a deeper dependence on drugs and alcohol. They tend to be more dependent on addictive substances than adults and become addicted more quickly.¹² Simply put, it is easier for teens to get hooked than it is for adults because the reward system that encourages them to take risks is the same system that responds to addictive substances and finds them rewarding.

In order to understand why, we need to keep in mind the unique chemistry and dynamics of the adolescent brain, which I covered in Chapter 3. To refresh your memory, adolescents' brains have a mature, highly developed *limbic system*, which responds to rewards, and a still developing or relatively immature *prefrontal cortex*, which handles complex decision-making and self-control.¹³ They are, to paraphrase psychiatrist and author Daniel Siegel, all gas pedal and no brakes.

Even adolescents who “know better” may end up doing something wrong in the heat of the moment. Why? When they're in an exciting situation or one where they are taking a risk, the reward-sensitive limbic system tends to take charge, overriding the more rational prefrontal cortex. In these situations, studies have shown that they are more likely to take risks or underestimate the consequences of their actions, even if they know very well the outcome could be harmful, or that drugs and alcohol are dangerous.¹⁴ Almost every teen shoplifts once, even if they come from an affluent family. It's not a question of need, but of the thrill, like fourteen-year-old Katie slipping a lip gloss into her jeans pocket while she was browsing at Sephora when her friend Alyce dared her to.

Novelty and Addiction

Humans seek out stimulating and different experiences. While we want security, we also like the feeling we get when we experience something new. This tendency can be seen in very young kids, who love to spin until they're dizzy or to be pushed in a swing higher and higher. It's all about the brain chemistry: new and even slightly scary experiences stimulate the parts of the brain that produce dopamine, the "happy" neurotransmitter, which makes us feel good, which makes us want more of the experiences that flood our brain with dopamine. When an exciting experience is unexpected or occurs randomly, the surge of dopamine is even greater, and we look for more opportunities to re-create the experience and the feelings associated with it.¹⁵ When the experience is combined with drinking or taking drugs, the impulse to repeat it is greater still. Drug-induced dopamine surges burn new neural pathways in the brain, increasing the chances of becoming addicted.¹⁶

Some of us are more sensitive to the effects of this neurotransmitter. Kids who are naturally prone to seeking new, exciting, and risky experiences and aren't afraid of getting hurt are at higher risk for addiction.¹⁷ Those who take more risks and care more about what other people think of them are at increased risk for hurting themselves in pursuit of new sensations.¹⁸

Teens also have more dopamine receptors than either adults or children. This enhanced sensitivity to dopamine may make teens more vulnerable to addictive drugs by increasing the pleasurable feeling linked to drug and alcohol use.¹⁹ Dopamine's effect on the hippocampus consolidates and maintains the memory of the experience, so they are more likely to do it again.²⁰

Everybody Else Is Doing It

Friends are critical to a healthy adolescent's social development. The catch-22 is that friends are also often the cause or stimulus for risky behavior and drug and alcohol use. Adolescents whose friends regularly smoke or vape tobacco or marijuana or who drink alcohol are more likely to use drugs or drink themselves.

Though you may have some influence over your child's choice of friends and significant others, the reality is that the final choice is theirs. Expressing disapproval or telling your child they shouldn't, or can't, see someone will often have exactly the opposite effect. You can, however, ask the kinds of questions that will allow them to think about these relationships.

Instead of saying, "I don't like Frank; he's not a good influence on you," you might ask, "Is Frank a good friend to you? What does having a good friend mean?" Saying, "I know you like Frank, and I have faith that you are taking good care of yourself and making the kind of choices that will not hurt you," tells your child you trust their judgment. Faith goes a long way with teens and young adults. If they know you have faith in them, they're more likely to stop and think, however briefly, before making a potentially dangerous or self-destructive choice.

Recent studies have suggested that social contexts, particularly peer influence, may serve as a motivational cue and can diminish cognitive control during adolescence, which leads adolescents to make riskier decisions in the presence of peers than when they are alone.²¹ Taking physical risks is a part of growing up and testing and finding one's limits; the goal is not to take risks away but to provide them in a more controlled

environment. When my very active younger son entered middle school, I knew that his need for novelty and sensation-seeking could get him into trouble. Lacrosse was the sport for him. He could play an aggressive and competitive game that involved sticks and hard balls and unpredictable situations, and at the same time was regulated by rules of conduct and supervised. Consider providing access to risky and exciting activities in controlled or supervised settings: an after-school program with indoor climbing walls or team sports like football, basketball, hockey, and lacrosse.

If sports is not their thing, there are other ways to provide thrills and stimulation for different kinds of kids. Indoor “skydiving,” an indoor trampoline park, or laser tag might be more suited to your child. I treated a family whose son hated group sports. He found the excitement he was looking for in escape room situations and during in-person and online scavenger hunts. Another option would be participating in multiplayer fantasy video games like *Fortnite*. My only caution here is that there should be limits on screen time.

Teens in particular are highly sensitive to social situations and peer pressure. Research shows that teens whose friends regularly use alcohol, cannabis, or tobacco are more likely to use those substances themselves.^{[22](#)} In fact, some studies have found that the degree to which a teenager’s peers use drugs or alcohol is in direct proportion to the amount of drugs or alcohol the teen will end up taking.^{[23](#)} Adolescents *should* be hanging out with their friends, but it’s also important for you to know who they’re hanging out with. Hard as it may be, the less judgmental you are about their friends, the more likely they are to talk to you about them and what’s going on in their lives, and if there are any problems in those relationships.

Alcohol, Drugs, and the Adolescent Brain

In case you are wondering whether it's really so bad for your kid to take drugs or alcohol, the science is clear. Drugs and alcohol are *very* harmful for the adolescent brain. When I'm talking about drugs in this section, I'm mainly referring to alcohol and marijuana, which are the most popular and widely used drugs among adolescents.

As you learned in Chapter 3, the adolescent brain is in the process of dramatic change, creating new brain cells and neural connections, as well as pruning those cells and connections it doesn't need. The brain also is creating new myelin, which makes up the fatty sheath around the nerves and allows the cells to transmit information to each other more efficiently.¹³

Drugs and alcohol interfere with these processes, disrupt normal development, and have lasting consequences on behavior. They reduce blood flow to the brain and damage the myelin, which affects how the cognitive and emotional parts of the brain communicate with each other.¹ The younger a child is when they start drinking, smoking, or taking drugs, the more likely they are to abuse them or become addicted. According to a study from 1998 by the U.S. Department of Health and Human Services, the risk of alcoholism increases 40 percent for those who start drinking before the age of fifteen.

Adolescents use larger amounts of alcohol in a single sitting than adults and are more likely to engage in binge drinking, or the consumption of five or more drinks for males and four or more drinks for females in a single two-hour period.^{24, 25}

Alcohol interrupts the formation of new cell growth in areas of the brain responsible for emotional regulation and may alter the reward centers of the brain.²⁶ It inhibits the growth of the hippocampus, which is responsible for learning, retaining

information, and working memory; teens who abuse drugs and alcohol have smaller hippocampi than those who don't.^{[27](#)} The earlier an adolescent starts drinking and the longer they drink, the more the hippocampus shrinks.^{[28](#)} Drinking can also impair development of the prefrontal cortex, the area of the brain responsible for complex thinking, future planning, and self-control. Brain scans taken of teens who abuse alcohol showed that their prefrontal cortices are smaller than those of teens who do not use alcohol.^{[29](#)} Alcohol use has also been linked to reduced functional brain activation, attention issues, and a decline in academic achievement.^{[30](#), [31](#)}

Adolescents may not feel the effects of alcohol as strongly as adults or appear drunk, but the potential for brain damage can be greater.^{[32](#)} It's like someone who can't feel pain and doesn't realize they've been injured. Adolescents are more prone to binge drinking because they don't "feel drunk," and they keep drinking, which puts them at greater risk for alcohol poisoning or endangering themselves and others by drinking and driving.^{[33](#), [34](#)} When you talk to your adolescent about drinking, encourage them to pace themselves and not drink one glass of beer or shot after the other. Explain that while they may not feel the effects immediately, more than one drink, particularly of hard alcohol, will pack a cumulative punch.

Due to the immediate feel-good effects of alcohol, there is a high risk of alcohol dependence or addiction, especially if there is a genetic or personality predisposition.

Marijuana and THC are just as harmful as alcohol, despite perceptions that they are relatively harmless. Recreational use of cannabis before the age of eighteen is linked with reductions in brain tissue, including reduced gray matter or brain cells.^{[35](#)} Cannabis use before the age of eighteen is also linked with

decreases in adult IQ. The longer the duration of use, the greater the decline in IQ and overall cognitive function.³⁶

Marijuana reduces synaptic pruning.³⁵ More synapses to communicate information may sound like a good thing, but it *decreases* the brain's ability to learn and hold on to information. Not surprisingly, it can result in poorer verbal skills and attentional difficulties. Remember Bill and Ted of *Bill and Ted's Excellent Adventure*?

Research also shows that marijuana and alcohol use are connected to increased depressive symptoms and paranoia, which can lead to self-harm. It may increase the risk of developing psychiatric disorders such as schizophrenia.³⁷

Other drugs are equally damaging. Chronic inhalant use, like sniffing glue, has been associated with permanent and irreversible cognitive deficits and structural brain abnormalities, and chronic cocaine use can result in disturbed memory, executive functioning, and how a person experiences and reacts to emotions.²⁹

Prevention

Preventing normal experimentation from escalating to abuse or addiction requires that you know your child. The difference between a child who experiments and one who becomes dependent or addicted may depend on your behavior and attitudes, and how available and present you are to them physically and emotionally. This is true for young adults who no longer live at home as well as younger adolescents.

People—adolescents in particular—use drugs and alcohol as a way to regulate intense or overwhelming emotions when they don't have the internal mechanisms or ability to do so. You can help your child build those resources by listening more than

talking and reserving advice for when they ask, but making sure they know you are there for the asking. I'm not saying that you should intrude on their privacy or demand that your child shares their feelings and concerns with you all the time. As in any other relationship, trust and respect have to be earned. Parenting is about teaching good judgment and not being judgmental; if you are reactive ("What's wrong with you? You've been drinking *again*?"), anxious ("I hope none of the friends or neighbors saw you in this condition!"), or punitive ("You're grounded for the next three months!") when they share their truths and their stories, then you won't be the one they share with.

Parenting is a nuanced high-wire act of persuading your adolescent to see your perspective without obviously ramming it down their throat. The goal is to help them to develop sustainable good judgment that is a combination of the values you transmitted to them and their individual ideas and preferences. You can encourage your kids to think for themselves by asking open questions. Instead of saying, "I know you are drinking. If you don't stop, you're grounded until I decide you're not," ask, "I wonder how you think your drinking is affecting you? Can you see a difference in your mood or your energy?" or "Are you concerned at all about the drinking impacting your schoolwork?" These kinds of questions encourage them to develop the ability to think for themselves.

Engaging with your adolescent this way requires being able to tolerate their expressing distress, sadness, anger, and yes, even rage toward you and others, and to allow them their individual perspective even when you don't agree with it (which I understand is no easy task). It requires being a safe container for their feelings rather than a sieve. Don't be too

hard on yourself if your own frustration and worry get the better of you; you're only human.

Having faith in your adolescent can become a self-fulfilling prophecy. I'm talking about the kind of optimism that means you believe in the inherent goodness and potential of your child. This kind of faith says we all make mistakes, and that's okay. I trust that with your life experiences and my support, you will make the right decisions.

Modeling behavior is one of the most important ways you can prevent your child from becoming addicted.³⁸ Kids who have parents who drink or use drugs as a coping mechanism on a regular basis are more likely to use them this way as well. You may not have a problem saying no to another drink, or only smoke on occasion, but your child still lacks the internal regulation that allows them to control how much they consume; it's much harder for them. In addition, their immature right brain doesn't always connect their actions with the consequences. And *please* don't listen to your friends who encourage you to drink or smoke with your kids! It's one thing to meet your twenty-three-year-old daughter for a beer and another to drink with your sixteen-year-old. It's not a good idea to overindulge with your kids, no matter how old they are.

I know that some parents say, "I'd rather my kid and their friends drink or smoke in my house where I can keep an eye on them," but that's a very bad idea. It breaks down the healthy and necessary boundaries between parent and child. Moreover, if any of the kids are underage, it's against the law. If something happens while they're in your home or after they leave—they get alcohol poisoning, for example, or have an accident on their way home—you're responsible, morally and legally. I know I've said this before, but you're their parent, not their friend.

Teach your children about the risks and consequences of drinking and drugs. Let them know that you're aware that they will be confronted with friends who are drinking and doing drugs and they may be tempted to try such behavior themselves. Educating them is not the same as approval; it's the recognition that your child will make their own decisions, but they need to have the best information to do so.

Make sure they know that if they drink, particularly hard alcohol, they won't feel the effects quickly. They shouldn't down one drink after another if they're not "feeling it"; it puts them at risk for alcohol poisoning. They should wait between drinks, and if they feel ill they should call you immediately or get to a hospital emergency room. Assure them that your first concern is their safety, and any discussion about the consequences of their decision will wait until they are well.

I would also let them know that it is a bad idea to drink or use drugs when they're feeling very depressed or anxious. While it may make them feel better for a little while, it won't address why they're feeling badly. They should also never drink or do drugs alone. It's better to be with friends they trust in case they need help.

If you have a child who ignores potential consequences and is always looking for new experiences, they are at risk. If they are socially isolated or easily influenced by their friends, they are at risk. If there is a family history of alcohol or drug abuse, then they are at risk. If they have been exposed to childhood adversity, trauma, or loss, they are at risk. If your teen is at risk, getting them therapy sooner rather than later may mean the difference between developing an addiction or not.

How Do I Know If My Teen May Have an Alcohol or Drug Addiction?

The signs of addiction may be obvious or not so obvious to parents. One or two of these signs may not indicate a serious problem, but when you see three or more signs I strongly suggest you have your child evaluated by a mental health professional. Denial or delay does not help your child. Of course, this only applies if your child is under eighteen. After that, they are legally adults and HIPAA laws apply. They don't have to share health information with you, nor do their doctors.

A friend shared a story with a happy ending. Her son was a freshman at college. He called home to tell his parents that he had been at an off-campus party and had drunk so much he became ill. Thankfully his friends took him to the emergency room where he was treated and released. Because he was underage, he went before a college disciplinary committee, and because it was a second offense he was told if there was a third offense he would be required to receive substance abuse counseling by the college. The disciplinary action? He was assigned to clean the bathrooms at an on-campus bar after closing (he was paid). There wasn't a third incident.

The following are some of the more obvious signs that an adolescent may have a substance abuse issue:

- Consistently oversleeping, or having trouble going to sleep
- A sudden drop in grades (from a B to D, for example) or a rapid decline in academic work
- Losing interest in activities they once enjoyed
- Dropping old friends for a new friend or group of friends
- Breaking rules such as skipping school or violating curfew
- Physical changes, such as rapid weight loss, frequent nosebleeds, bloody or watery eyes, shakes or tremors
- Sudden use of room deodorizers, mints, gum, or anything else to cover up the smell of alcohol or marijuana

- Unexplained missing cash or pawnable objects from the home
- Changes in personality, such as regularly seeming more tired, more manic, or more emotionally volatile than usual

There is a difference between the signs parents may see versus the symptoms that a mental health professional may use to diagnose a disorder. To get a diagnosis of substance use disorder, a mental health professional must first conduct a careful diagnostic interview to assess whether there is a problematic pattern of substance use or behaviors that are causing a person distress and impairing their functioning in a clinically significant way. There is some overlap in the signs a parent may notice and clinical criteria.

If your child exhibits at least two of these eleven symptoms, a mental health professional will probably recommend treatment for a substance use disorder.⁵

- Failure to fulfill obligations (not showing up at school or work, missing important appointments or meetings because of drug or alcohol use)
- Taking risks to get drugs or alcohol, or engaging in risky behavior under the influence of those substances
- Continued use despite social or interpersonal problems, such as losing friends or a romantic partner or a decline in grades or job performance, because of substance abuse
- Uncontrollable cravings for drugs or alcohol
- The need to drink more or use more drugs to get the same effect

- Withdrawal symptoms—shakiness, sweats, irritability, nausea, achiness, fatigue, anxiety, hallucinations—when not taking drugs or drinking
- Using for longer periods or in larger amounts than intended
- Cannot stop drinking or using no matter what they may consciously want to do or try
- Spending large amounts of time acquiring and using drugs or drinking
- Choosing drinking, drug use, or related activities rather than activities they previously enjoyed
- Continued use despite physical or psychological problems

Treating Drug and Alcohol Addiction

If your adolescent is suffering from a substance use disorder, it is critical to get them treatment as soon as possible. Many different types of treatments help address substance use disorders, and the good news is that studies show that most types of treatment result in meaningful reduction of substance use.³⁹ However, adolescents are at greater risk of dropping out of treatment compared with adults because they are less motivated to change, do not perceive treatment as suitable or necessary for themselves, and are more likely to be in treatment because of pressure from their parents or other adults.⁴⁰

If you are concerned that your young adult child has a substance abuse problem, you don't have the authority to force them to get help, but you can still offer them the opportunity

and encourage them to take it. You can always be there to give them love and support.

Three types of treatment are available for substance use disorder. *Short-term residential* is up to a month of inpatient treatment with the primary purpose of diagnosing and detoxing, followed by outpatient treatment (more to follow). *Long-term residential* is no fewer than three months and up to a year. This is used in cases of harder-to-treat addictions, like alcohol abuse and opioid addiction. There are also therapeutic schools for teens, which are essentially boarding schools that offer addiction therapies. *Outpatient treatment* is beneficial if you catch an addiction early enough.

All these modes of treatment take a multidisciplinary, holistic approach, which includes some or all of the following:

- A psychiatric evaluation, to determine if there are any underlying psychological conditions that need to be dealt with and to consider if medication is appropriate
- Individual psychotherapy
- Group therapy
- Family therapy
- A religious or spiritual component
- CBT and/or mindfulness training as well as relaxation, yoga, and nutritional counseling to help manage stress
- Supportive medication, if necessary, under a doctor's supervision. This may include antidepressants, antianxiety drugs, or aversive medications, which make the experience of drinking alcohol or taking drugs physically unpleasant.

These programs are often covered by insurance. Depending on your coverage and what programs are available in your area, a program may not have all the elements previously listed. If they do not, you can supplement components like nutritional counseling, exercise, or yoga with separate local providers.

The Most Commonly Used Drugs by Adolescents

Adolescents' drugs of choice are constantly changing. In the 1970s, it was Quaaludes (and marijuana), in the 1980s it was cocaine (and marijuana), in the 1990s and 2000s, ecstasy (and marijuana).^{[41](#), [42](#)} Parents should stay on top of the most current temptations and understand their risks and health implications.

Each drug class has a different impact on a teen's developing brain, which can be understood in terms of underlying mental health issues. An adolescent who is depressed may choose a stimulant while a teen who is anxious may choose a sedative or depressant. A teen who is in the most intense kind of emotional pain may choose a painkiller like an opioid, which numbs physical *and* emotional pain.

Sedatives

Sedatives are drugs that reduce brain activity, producing a calming effect, and may induce sleep. They include alcohol, marijuana, heroin, and ketamine.

Stimulants

Stimulants are drugs that increase the speed of messages between the brain and the body. They increase the activity of the central nervous system and can make a person feel more awake, alert, confident, or energetic. They include nicotine,

cocaine and crack, methamphetamine and crystal meth, MDMA and 4-MTA, and “bath salts.”

Hallucinogens

Hallucinogens are drugs that alter perceptions, thoughts, and feelings and cause distortions of a person’s perception of reality by disrupting the interaction of nerve cells and the neurotransmitter serotonin. They include psilocybin mushrooms (magic mushrooms or shrooms), LSD, and PCP (angel dust).

Prescription drugs are also widely used and abused by adolescents. They include amphetamines, which are often used to treat ADHD; opioids like oxycodone and hydrocodone; benzodiazepines like alprazolam (Xanax), diazepam (Valium), and clonazepam (Klonopin); and barbiturates.

In the event of an opioid overdose, there are medications that reverse the effects of the drug and can save a life. Naloxone is effective and widely available. It is administered as a nasal spray or an auto-injectable. After it is administered, the person should be immediately taken to the nearest emergency room.⁴³

Having faith in your adolescent is important, but so is being prepared if there is a problem. Drug and alcohol use is not necessarily pathology. However, if a person has underlying emotional issues and is exposed to environmental stress, experimentation can lead to abuse and addiction.

You cannot control what your child does when they are not with you, and for many people, experimenting with alcohol and

sometimes drugs is a rite of passage into adulthood. You can, however, give them emotional security, focus on understanding rather than punishment, set clear but flexible boundaries, and be a sounding board to help them regulate their emotions. If they show signs of losing control or struggling with addiction, you can get them help as soon as possible. The sooner you address the issue, the more easily you can get them back on a healthy path.

CHAPTER 9

TECHNOLOGY, SOCIAL MEDIA, GAMING, AND GAMBLING

It doesn't take a social scientist to tell you that one of the biggest differences between teenagers' lives today and those of a generation ago is the sea change brought by technology and social media. Technology use—email, cell phones, tablets, computers, gaming, and social media—has changed the landscape of how our adolescents socialize, interact, and communicate with us and with one another. It has permanently altered our children's social-emotional development. Technology is, for better or worse, a tide we cannot push back or close our eyes and wish away.

Like any new developments in our social history, technology use has its pros and cons. For many adolescents it has become a way to stay connected to their friends and explore the world beyond the bounds of their geography. For others, particularly those with underlying mental health issues like depression, anxiety, or ADHD, their technology use can more easily tip over into abuse or addiction.

I often have parents come to see me because they are annoyed, anxious, and sometimes afraid about the impact social media and gaming are having on their child. I agree that parents are correct in being vigilant about the impact and effect of technology on their kids, but it may not be the big bad wolf

that many are making it out to be. Many parents come to see me hoping I will demonize technology and are often surprised to find out that I believe the key is moderation and regulation, not abstinence.

What Role Does Technology Play in the Mental Health Crisis?

Some researchers have asked whether technology and social media are the main culprits in the adolescent mental health crisis. While not the sole contributors, some evidence shows that technology and social media influence teens' mental well-being. For example, social media, while it offers an easy way to connect with others, can also exacerbate feelings of social isolation. Smartphone use in the evenings has also been associated with less sleep, an important piece of the mental health picture. In 2015, 57 percent more teens were sleep deprived than those surveyed in 1991, and between 2012 and 2015, 22 percent more teens got less than seven hours of sleep a night.^{[1](#)}

According to the Pew Research Center, 95 percent of teenagers own or have access to a smartphone, and 45 percent of teens say that they use the internet "almost constantly," with about nine in ten teens using the internet at least several times a day. It doesn't take Sherlock Holmes to notice that the increase in teen mental distress symptoms began its steepest ascent after the smartphone was released in 2007 and reached significant market penetration around 2012.

Probably one of the most definitive recent studies showing a link between social media use and mental distress symptoms came out of the University of Pennsylvania in late 2018. Researchers there demonstrated that when a group of

undergrads reduced their social media use to just ten minutes a day it resulted in significant decreases in symptoms of loneliness and depression. Several other studies have also shown links between social media and mental distress. For example, Facebook and Instagram usage has been found to correlate with depression symptoms.² One study showed that after one hour of screen time a day, every additional hour of screen time is associated with lower psychological well-being.³ Increases in screen time have also been shown to be correlated with greater unhappiness. A study showed that eighth graders who were heavy users of social media had a 27 percent increased risk of depression. Most alarming is that teens who spend more than three hours a day on a screen are 35 percent more likely to have a risk factor for suicide. Teens who spent more time on off-screen activities, on the other hand, such as hanging out with friends in person, playing sports, attending religious services, or even doing homework, were much less likely to be unhappy.¹

However, experts are still far from reaching consensus on whether technological change is the main driver behind the past decade's increases in adolescent mental distress. Some critics of these studies say that they overstate the significance of their findings and in reality technology only has a small impact on teens' overall well-being. A 2019 study published in *Nature* noted that "the association of well-being with regularly eating potatoes was nearly as negative as the association with technology use, and wearing glasses was more negatively associated with well-being."

What is the true picture behind these conflicting stories? As is usually the case, the truth is more complex than simply "technology is all good" or "technology is all bad." A closer look

at exactly how teens are using technology and social media can provide us with a better understanding of what precisely is happening.

When Does Technology Help? When Does It Hurt?

In 2018, the Pew Research Center conducted an exhaustive series of surveys into teens' habits regarding social media use. The results give us quite a bit of information about how teens are using technology and how they feel about it. First of all, teens themselves don't agree on the overall impact of technology. Thirty-one percent of teens say social media has a "mostly positive" effect on their lives, 24 percent say it has a "mostly negative" impact, and 45 percent say that the effect is neither mostly positive nor mostly negative.

In terms of positive impacts, teens tend to highlight the increased ability to connect with their friends. Eight in ten teens ages thirteen to seventeen say that social media makes them feel more connected to their friends' lives, and two-thirds of teens say that social media helps make them feel that they have people who will support them in tough times. Teenagers spend a lot of time socializing online and tend to say that social media makes them feel more included than excluded, more confident than insecure, and more outgoing rather than reserved.⁴ Even video games can help teens feel more socially connected, especially boys: 78 percent of gaming teens say that video games make them feel more connected to friends they already know. Girls, by contrast, tend to spend more time communicating via text and instant messaging.

While teens enjoy feeling connected via social media, they simultaneously experience other, more negative reactions: 45 percent of teens say they feel overwhelmed by all the drama on

social media, 43 percent say they feel pressure to post content that makes them look good or will get a lot of likes and comments, and 26 percent of teens say social media makes them feel worse about their life.⁴ Many teens feel left out when they see their friends posting content without them.

Tom and Shelby came to see me because their fifteen-year-old daughter, Fiona, was feeling depressed. She was not part of the popular crowd in tenth grade but was, for the most part, okay with her place in the high school pecking order. Fiona had friends, her parents said, but like their daughter, they were a little shy, smart, and perceived by the other kids as “nerdy.” She had told her parents she found the popular girls shallow, vain, and mean.

The problem started when Fiona found out her best friend, Alice, got invited to hang out with the popular girls down at the lake and lied to her about it. Fiona discovered the lie when she was on the Find My Friends app and confronted her friend. Alice apologized, but she and Fiona got together less and less. Each time Alice said she couldn’t get together, Fiona would check Find My Friends to see what Alice was doing. She also realized other friends were getting together without her. She spent more and more time on social media platforms scrolling through posts from friends and schoolmates documenting social events to which she hadn’t been invited. When other friends reached out to her, she wouldn’t respond to their texts or found excuses not to see them.

Fiona was feeling sadder and sadder and realized she needed help to break her obsession with tracking her friends. She told her parents she wanted to see a therapist because she felt like a loser; she hated herself and the girls who ignored and excluded her.

I was able to guide Tom and Shelby to a therapist for Fiona who specialized in seeing adolescent girls. What seemed to them like a social media addiction was actually the result of social anxiety mixed with self-esteem issues. It was key to intervene as soon as possible so that her use of social media, which was damaging her already fragile self-esteem, didn’t do more harm.

Fiona agreed to limit her participation on social media, and she and her parents agreed on specific times when she could use certain apps. She kept a record of the times she logged into her favorite apps and how long she spent on each. They encouraged her to nurture friendships with girls who appreciated her. Shelby, who ran a small but successful public relations firm, shared her own experiences of being excluded from the in crowd and pointed out that she still remained close with some friends from high school.

Fiona had always loved music, and her parents told her they would pay for singing and acting lessons. For her birthday they bought her a microphone and recording system. She found a new group of friends in the theater club at school and got roles in several productions. It was difficult for Fiona to stop using Find My Friends, but as she spent more time with her new friends and rehearsing for school shows, she felt the need to check it less and less.

Social Interaction: Online and In Person

As you may have noticed, the outcomes previously noted are all related to social behavior: technology is good when it encourages good social interactions, and bad when it fosters bad ones. Technology can help teenagers feel more connected to one another, although the most valuable social interactions are still in person and face-to-face.

Today's adolescents are spending less time hanging out with one another in person. Over 36 percent of teens feel that they have too little face-to-face time with their friends, 41 percent feel that they are too busy to find the time to hang out with friends, and 33 percent say that it is easier to connect online than physically in person.⁴ A recent study looked at adolescents from 1976 to 2017 and found that teenagers in the 2010s spent less time on face-to-face interactions than teenagers of previous generations. Even controlling for homework, paid work, and extracurricular time, high school seniors in 2016 versus the late 1980s spent as much as an hour less each day interacting in person. These changes coincided with a sharp increase in feelings of loneliness among teens after 2011.⁵

As much as social media might help teens connect with their friends, screen time simply cannot compete with the power of in-person interaction: teens who spend an above-average amount of time with their friends in person are 20 percent less likely to be unhappy than those who hang out for a below-average amount of time.¹ Teens today acknowledge that they are probably spending too much time on their devices. Nine in ten teens think that spending too much time online is a problem for people their age, and 60 percent say it is a major problem.⁶

What Can You Do About It?

Social media and technology may help adolescents feel more connected, but other times technology can make teens feel more insecure or serve as a platform for toxic behavior and bullying. No silver bullet will remove all the bad parts of technology and leave the good behind. However, you can work with your children to identify how technology is helping them in their lives and how it is hurting, and help them adjust their habits accordingly.

What types of apps and websites are your adolescent kids using? Over the past few years, teens' platform use has changed dramatically. In 2015, 71 percent of teens reported using Facebook while in 2018 only 51 percent of teens did so. In 2018, newer apps such as Instagram (52 percent) and Snapchat (41 percent) were much more popular than in previous years, and other platforms such as YouTube (32 percent) had gained in popularity.⁷ Adolescents' preferred apps and websites will continue to change with the times. Talk to your kids about what they're using. You may not be able to dictate which platforms your kids can use, but you *can* help them identify which ones make them feel badly or attacked. You can also encourage them to find other ways to connect with their friends: different apps, text messaging, and even using the phone to talk.

The American Academy of Pediatrics recommends no more than two hours per day of "quality programming" screen time, including phone, television, computer, and video games. If your young adolescent doesn't yet have a smartphone or gaming system, talk to them before they open the box and discuss how much screen time they're allowed and if there are any apps or platforms that are off-limits.

The best way to make powerful social connections is still spending time face-to-face. You can play an important role by

encouraging and facilitating those connections. Parents who create a welcoming home can make a difference in whether their child invites friends over or not. This may mean making your house or apartment the most comforting and comfortable place for your child and their friends to hang out. You may have to tolerate a messy space and some noise and giving over a portion of a den or your basement to make a hangout space for teens. Be prepared to feed them! My son's middle school friends came over to hang out on many afternoons after school because they knew that homemade macaroni and cheese and chocolate chip cookies were waiting for them. If you don't have the time or inclination to cook, popcorn, chips, and pizza work too. If you have the space and resources, a Ping-Pong or pool table, dartboard, basketball hoop, or gaming system with extra controllers can make your house a fun and stimulating place for your teen and their friends.

One of the most important things you can do as a parent is to model correct behavior. Walking the proverbial walk is more important than talking the talk. A staggering 51 percent of adolescents say that their parents are sometimes distracted by their phones while they are trying to have a conversation, and 14 percent say that their parents are *often* distracted by their phones.⁶ If you're constantly on your phone, tablet, or computer, you shouldn't be surprised if your kids follow suit. Try putting your phone or other devices away while you're at dinner and during family activities, and when you're interacting with your kids. I realize that if you're a medical professional or first responder this may not be possible, but you can practice only responding when it's actually an emergency.

It's also important to discuss and model online conduct: what should and should not be shared, what kind of content to avoid,

and how they should engage with others or not.

When Does Technology Use Become Abuse or Addiction?

Justin and Sharon were worried. Their thirteen-year-old son, Lowell, had begun locking himself in his room after school and on weekends to play multiplayer video games. He'd stay at the console for hours, rebuffing efforts by his parents to coax him away from the machine, and sometimes refusing to come out for dinner. Lowell had been a lively, social, athletic boy with tons of energy, they told me. It was when he got an Xbox for his twelfth birthday that his behavior began to change.

When I asked if there had been any changes or disruptions in the family, Sharon told me that Lowell's ten-year-old sister suffered from asthma and required a lot of attention to manage her condition. Lowell had started middle school the year before, and while his academics were fine, his parents did notice that he didn't see friends as often and wasn't as excited about school as he had been. After he didn't make the cut for the baseball team, he had moped around for a few days. Justin, an accountant, said his son was going through "that awkward stage" of puberty, growing three inches in six months, starting to break out, and growing body hair. But as far as he could tell, his son was fine. Lowell didn't seem to want to talk to them about anything that was wrong, so they assumed he was coping. They consoled and reassured him that the coach made a mistake in not adding him to the team and that if he was having a rough time at school, he'd get through it.

Justin and Sharon couldn't see that their son was upset by the changes happening to his body and having trouble finding his place in the social order at school because it made *them* uncomfortable. As long as Lowell didn't talk about it, they could pretend that nothing was wrong. Lowell sensed his parents weren't interested in hearing that he wasn't coping, so he would drown his concerns and worries in his video games, where he could be the hero or the victor. His online relationships with other gamers were simple, and no one judged him for his awkwardness or acne.

Working with me, Justin and Sharon came to understand that their son was going through a perfectly normal transition to adolescence, but because they were not present for him physically or emotionally, he had taken refuge in his Xbox and with his virtual friends. They made a conscious effort to engage with their son and draw him out. They also set limits on gaming time, keeping it to a few hours on weekends. Justin started coming home in time for dinner more often and spent more time with Lowell, asking to play video games with him, watching Lowell's favorite TV shows with him, or going to the park and shooting hoops.

When Lowell and his sister came home from school, Sharon practiced sitting and listening to her son and learned to hear the good and bad of Lowell's day without jumping in to reassure him or getting up to start dinner because his feelings made her sad or uncomfortable.

Justin noticed that Lowell enjoyed their time shooting hoops and suggested he go out for the basketball team. Lowell made the team, and while he wasn't a starter, he found he loved the game and the team bonding. He also found his social groove at school when he joined the Audiovisual Club, where real teens bonded over technology in real life rather than virtually.

Certain behaviors, like obsessive gaming and online gambling, trigger the same kind of response in the pleasure and fear centers of the brain that addictive substances do. As with all addictions, an element of risk enhances the excitement. As with substance addiction, the more someone engages in the behavior, the more activity is needed to get the same satisfaction; also like substance use, there are lines between use and abuse, and abuse and addiction.

Gaming and gambling are self-soothing behaviors that help to quell anxiety and depression and to temporarily cope with painful feelings due to losses, trauma, or emotional insecurity. Kids who abuse technology often use these games to escape the pressures, disappointments, and responsibilities of becoming a young adult, as well as to release aggressive feelings. They use games to take risks they cannot or do not take in real life. They may also use video games to feel competent when they have difficulties socially, academically, and emotionally. In the worlds they create, they can be anything they want to be and be not only empowered but victorious.

Of course, not all gaming is problematic. If played in moderation, video games can help to promote fine motor skills and heighten cognitive responses, problem solving, and observation skills. According to the Pew Research Center 83 percent of girls and 97 percent of boys report playing some form of video games, which can offer connection with like-minded peers.⁷ However, if gaming becomes an obsession or begins to interfere with other aspects of everyday life, including school and family relationships, parents need to intervene.

A 2009 study from Iowa State University found that 88 percent of American children between the ages of eight and

eighteen played video games, and of those, 8.5 percent (that's roughly 3 million of 45 million youth) suffer from *pathological* video game use. Boys were four times more likely to be pathological gamers than girls. These kids did worse in school, had trouble paying attention in class, and reported feeling "addicted." They were twice as likely to suffer from ADHD. Symptoms included spending increasing amounts of time and money on video games to feel the same level of excitement, irritability or restlessness when play is scaled back, escaping problems through play, skipping chores or homework to spend more time at the controller, lying about the length of playing time, and stealing games or money to play more.

If played too frequently, video games can increase anxiety, aggression, and hyperactivity, and decrease frustration tolerance. Internet gaming has been so concerning internationally that in 2017 the World Health Organization announced that in the *International Classification of Diseases, Eleventh Revision*, gaming disorder would be identified as a new disorder.⁸ In some countries, including South Korea and China, video gaming has already been recognized as one and treatment programs have been established.

Internet gaming disorder (IGD) often compensates for deep feelings of insecurity, emotional emptiness, and inadequacy. It's a form of manic activity that kids use to deal with depression. Kids who are obsessed with gaming may have social, academic, or emotional difficulties; they feel powerful and competent in their virtual world. The APA has identified gaming abuse as an addiction and a serious form of mental illness in the *DSM-5*. If you're concerned that your child's use has become abuse, see the following list. If their behavior meets five or more of these criteria, they may have IGD:⁹

- Preoccupation with gaming
- Withdrawal symptoms (sadness, anxiety, irritability) when gaming is taken away or not possible
- The need to spend more time gaming to satisfy the urge
- Inability to reduce playing time or to quit gaming
- Loss of interest in previously enjoyed activities due to gaming
- Deceiving family members about the amount of time spent on gaming
- The use of gaming to relieve negative moods, such as guilt or hopelessness
- Risking or losing a job or relationship due to gaming

Online Gambling

Online gambling is a significant problem, affecting between 2.1 and 2.6 percent of adolescents.^{[10](#)} It gives kids instant gratification; like gaming, it triggers both the pleasure and fear centers of the brain, giving them a hypervigilant high. Deep feelings of insecurity and inadequacy can be temporarily allayed with quick and impulsive successes, even though those successes are followed by failures or losses. Kids gain confidence from their wins and see them as a badge of competence and a reassurance of their value. However, too often they ignore their losses and believe if they play just a few more rounds, they'll start winning again. As with other activities and substances that overwhelm the pleasure centers, a tolerance to the effects builds up over time.

Bradley, a college sophomore, began gambling on fantasy football. Unable to cover his losses, he began selling his personal belongings to pay for his habit, including a prized gold watch his grandmother had given him when he graduated high school. Bradley was hooked on the emotional rush he felt when he won. His life became centered around the game and betting; he stopped studying, stopped going out with friends, and stopped communicating with his family, who were very concerned about his mental health. His roommate complained that he kept him up because he was playing into the early morning. Bradley would stop for a few days, but then he would revert to his old playing habits.

His parents finally had to intervene. They spoke to the dean, who agreed to let Bradley go home and suspend his studies for the remainder of the semester.

In my therapy sessions with Bradley, I learned that he had been diagnosed with dyslexia in middle school. He was smart, but his learning disability meant he had to work hard to keep up his grades. But with his parents' support, outside tutoring, and his school's services, he was able to keep up with his academically competitive classmates. When he went to a large university, however, he lacked the support systems he had at home, and there were no accommodations available at the school. Bradley overslept and missed classes, forgot assignments, or turned them in late. Frustrated, ashamed, and feeling out of control, he turned to something he knew he was good at. Bradley was able to connect his obsession for sports gambling to his depression. Once he was able to make this emotional connection, it opened up a discussion about whether he was at a school that could provide him with support for his learning issues and help him identify and build on his strength in math and statistics and his passion for sports.

Bradley transferred to a smaller school that offered support and accommodations for students with learning disabilities, and switched his major from prelaw to statistics, with a minor in sports management. Engaged and enthusiastic about his studies, he still played fantasy football, but for fun, and not at the expense of his schoolwork.

Technology, social media, and video games are not the enemy, and treating them as such will alienate your child. Open communication around the use of technology includes setting limits if your child lives at home. Self-awareness is important here; there is a fine line between setting limits and becoming intrusive and anxious. Showing you're interested in their particular interests—whether it's a video game they love, cute pet videos on Instagram, or dance challenges on TikTok—will give you some insight into whether they are using technology in a way that benefits them or whether there is cause for concern. If your child is under eighteen, having faith in them is not

mutually exclusive from touching base with them and letting them know that you may check their social media periodically. If you know when the signs of use are becoming abuse, or when mental health issues such as anxiety or depression become merged with technology use, you can be prepared to intervene sooner rather than later.

CHAPTER 10

BULLYING AND SOCIAL MEDIA

In 2014, the CDC released its first uniform definition of *bullying*, which included “unwanted aggressive behavior, observed or perceived power imbalance, and repetition of behaviors of high likelihood of repetition.” The two modes they identified were *direct* (bullying that occurs in the presence of a victim) or *indirect* (not directly communicated to a victim, such as spreading rumors). They also identified four types, including physical, verbal, relational (efforts to harm someone’s reputation or relationships), and damage to one’s property (which could include deleting the victim’s privately stored electronic information).

Bullies and bullying have always existed, but in the age of unregulated social media, bullying has gone from being a schoolyard problem, where you could identify an aggressor or aggressors, to cyberspace, where multiple anonymous posters hound and harass their victims. Social media has given adolescents a platform where they can let loose their destructive impulses and hostility without being held accountable; it’s like a virtual *Lord of the Flies*. If that wasn’t enough to worry about, adult predators are “catfishing” kids and teens by assuming false identities, then luring teens into communicating and meeting with them.

Some bullying falls into criminal categories such as harassment, hazing, or assault. However, some of the most

destructive and abusive bullying occurs off the radar of adults and law enforcement.

Is It a Big Problem?

In a word, yes. A 2007 study found that middle school students are most at risk for bullying. Bullying behavior can include: name calling, teasing, spreading rumors or lies, pushing or shoving, hitting or kicking, leaving out, threatening, stealing belongings, sexual comments or gestures, or abusive social media posts. Bullying happens wherever kids gather in the community. In middle school, bullying occurs in the classroom, the hallway or lockers, the cafeteria, gym or PE class, the bathroom, and the playground or at recess.¹ Adults often don't know what to look for and don't know how to respond. In addition, only about 20 to 30 percent of students who are bullied notify adults about the bullying, which makes it even harder for adults to intervene in this secretive world of adolescent aggression and abuse.²

A 2017 report from the National Center for Education Statistics and the Bureau of Justice found that approximately 30 percent of young people nationwide admit to bullying others, while 70.6 percent of young people say they have seen bullying in their schools and 70.4 percent of school staff have seen bullying. In that same study, 49 percent of children in grades four to twelve reported being bullied by other students at school (including cyberbullying) at least once during a one-month period, and 30.8 percent reported bullying others during that same period of time.

The Secret World of Adolescents

There is a disconnect when it comes to kids sharing with adults their pain of bullying. According to the i-Safe American survey of student bullying, about 58 percent of kids admit to never telling any adult, including parents, when they've been the victim of a bullying attack. Only 23 percent of students who reported being cyberbullied notified an adult at school about the incident.^{[2](#)}

Teens feel shame when they are bullied. They feel frightened that, if they tell adults, the bully or bullies will retaliate and the bullying will get worse. Some kids are afraid that they will be judged or even punished by their parents and teachers for being weak. Some of this fear is based in reality. Parents often get angry when their kids are bullied; a child might interpret that as anger toward them. In families, schools, or other organizations that value self-sufficiency over asking for help, kids can take on too much of the burden of trying to “fix” things on their own. While it is important for parents and teachers to empower kids to address bullying issues on their own if possible, expecting kids to handle things on their own in every case is both unrealistic and potentially dangerous.

Is Your Child at Risk?

Any difference, real or imagined, that sets an adolescent apart from their peers can make them a target. According to a study conducted at the University of Illinois at Urbana-Champaign, students reported being bullied due to race or religion; for behavioral and emotional disorders, including autism; for intellectual and learning disabilities; and for health impairments. Of LGBTQ+ students, 70.1 percent were verbally bullied because of their sexual orientation and 59.1 percent because of their gender expression.^{[3](#), [4](#)}

Race plays an important role in the perception of “otherness.” Black, Hispanic, and Asian students report being bullied at school. More students from suburban areas than urban areas report being bullied with regard to race; this may be because rural and suburban kids are less exposed to racial diversity.²

Is Bullying “Normal”?

Bullying behavior isn’t unexpected during adolescence, especially during middle school, because of the normal developmental challenges that all teens face with emotional or mood regulation, and finding their place socially. Some of these developmental issues your child may grow out of, and with others they may need help. A limbic system unmoderated by the prefrontal cortex means that adolescents have difficulty regulating, controlling, and filtering intense emotions such as aggression and anger, and controlling their impulses. Those feelings are too often displaced on the most vulnerable targets.

Remember when your child was in grade school? Sometimes if they could keep it together during the school day, they would fall apart at home. You can be there as a buffer for your adolescent child in the same way you were when they were younger. Can you make it safe for your child to express their angry and aggressive feelings at home—verbally—to you, without judging or criticizing them for having those feelings? If you can, they are less likely to take those feelings into other relationships and the outside world.

We are not born empathic—that is, with the ability to put ourselves in another’s shoes emotionally. We learn it when our parents are sensitive and empathic toward us as children and internalize it over time. Adolescence is the time when teens are

taking those lessons from interacting with their parents and learning to become empathic toward others. However, in the process of creating their own identity, teens often retreat into a cocoon of self-centeredness to later emerge as caring people. This self-centeredness does have a dark side; it's an ingredient in the bullying dynamic. In part it is because adolescents are so self-focused that worrying about someone else is not high on their list of things to do. They are also afraid of becoming a target of the bullies and eager to preserve themselves. The good news is that kids *do* become increasingly aware of others' feelings and often regret later on not standing up to the cruelty of their peers.

Bullies are often from homes with constant emotional conflict and other challenges in the family, including emotional neglect, overly harsh discipline, or physical, sexual, or emotional abuse.⁵ Bullies often treat their peers as their parents or other family members treat them; their behavior is a way to overcome feeling so powerless at home. A bully whose behavior is not challenged or corrected often develops a deep sense of guilt and an uncomfortable and frightening feeling of being all powerful (which they are not), which stunts their personal development and, paradoxically, diminishes their sense of self-worth.

Boys and girls have different ways of expressing their aggression. Boys are more comfortable expressing their anger and aggression physically while girls express their aggression more verbally, using emotional bullying and social manipulation.² Boys who bully may physically beat up another boy, whereas girls are more likely to cyberbully, spread rumors, tease, ruin someone's reputation, socially exclude, and be all-around jerks to other girls.

Middle School Is the Worst

Middle school is the most traumatic time for kids. It marks the beginning of puberty, which means that their bodies are changing in ways that alter their appearance (not always for the best) and their moods. There is a desperate need for peer approval. I know many adults who describe their time in middle school as a nightmare.

My own middle school experience is responsible in many ways for my path as a social worker and psychoanalyst. I was miserable in middle school. I was one of those kids who was teased and bullied mercilessly by a group of mean girls. My three older sisters had left home by the time I was ten years old, and I grew up like an only child with older parents: a mother who was emotionally fragile and easily overwhelmed by everything, and a gentle and loving father.

In elementary school I had friends and did fine in school. When I was twelve, my parents retired, and we moved to Florida where I spent seventh grade in a small private school. If there were incidents of bullying or teasing, the teachers and administration were on it before it became a problem. After a year we moved back to our previous home, a small town in Connecticut, where I entered eighth grade at the public junior high school. I was happy but nervous to return and wondered how my friends may have changed.

I returned to a large, socially unsupervised environment. It didn't help that I was a bit chubby and sexually a late bloomer, and had crooked teeth, acne, and an ethnically Jewish nose that made me feel incredibly self-conscious. I did not go out into the world with great confidence; today I might have been diagnosed with social anxiety. School felt like the Wild West, with no sheriff in town. The girls I had known in sixth grade

ignored rather than welcomed me. The mean girls prowled the hallways and bathrooms looking for vulnerable prey; I was not their only target. I was ashamed of being a victim and mostly I internalized the feeling that I was worthless and rejectable. My parents had no idea how to help me deal with the situation; the best they could offer was to suggest that I sit near the teacher at the front of the room, but that didn't stop the comments, the laughing at me, and the whispering behind my back.

The adults seemed clueless as to what was going on until the girls began doing it more obviously and publicly. One day we were watching a movie in social studies class. After the movie was over, I felt the back of my head to find it was covered with chewing gum balls that I could not get out of my hair. I went to the teacher and began to sob. She took me to the nurses' office, where the nurse called my mother and told her to come and pick me up.

My mother was enraged at my persecutors, but my parents were also frightened it would make it worse for me if they got involved and reported the incident to the principal, and I agreed. We had to cut my hair at the roots to get the gum out, leaving me with a bald spot on the back of my head until the hair grew back.

My parents tried giving me pep talks, but that didn't help. My sweet father told me, "You are a Komisar, and we are tough and strong," but I didn't feel tough and I didn't feel strong. I just felt lonely and sad and rejected by my peers. When the girls realized there would be no consequences for their gum attack, they started making abusive prank phone calls on which they said inappropriate sexual things and then laughed and hung up. Even when my father insisted I no longer answer the phone and only he or my mother picked up, the calls continued.

Finally, my parents were done. They called the police, who agreed to tap our phone line and trace the calls. Officers spoke with each and every one of the girls' parents, and finally the calls stopped. My parents offered to send me to a smaller private school, but by that time I had two good friends who, like me, were being bullied and I didn't want to abandon them. I felt a need to face these girls. Supported by my parents and friends, I returned to school, rose above my pain, and was able to look to the future of high school and eventually college. I put my head down and studied hard, focusing on schoolwork and riding horses, singing, running, and working out. I got my braces off, started taking Accutane to clear up my skin, and with my new fit body took on high school with more confidence.

High school was better than junior high school. The mean girls seemed to be meaner to one another than those outside their group. I spent time with my best friend, Fiona, who was my savior and my solace; to this day I owe her such a debt of gratitude for our bond.

But most important were the love and emotional gifts my parents had given me growing up, which helped me see that the future could be better than the present. I had the resilience to cope with the abuse of others because of my steadfast love and support at home.

Group Behavior Dynamic

Adolescents need their peer group to help them separate from their parents. It's why belonging to a social group is so important in middle school and high school. Groups serve as protection and support. Peer pressure is one explanation for why many adolescents participate in risk-taking behaviors, as well as acquiescing to, or participating in, bullying. Young

people, especially teens, are afraid that if they defy the group leader's or other group members' bullying behavior or speak up, they too will be an outcast. The group behavior that can be so supportive of adolescents can also lead them astray.

Think of adolescents like a wolf pack. There is an alpha, sometimes two, to whom the rest look for direction. They are usually the most aggressive, bossy, and self-assured. Sometimes their seeming self-assurance is a cover for deep insecurities and problems at home; sometimes they're more like benevolent dictators. The problem is that if there is a member of the pack who is obviously weaker or different, doesn't seem to quite fit in, or has different ideas, then the leader and the rest of the pack will reject and drive out that member. That may be a successful evolutionary strategy for wolves, but one that we as humans no longer need.

The Dark Side of Sharing

The social pressure and drama created by social media provide a perfect storm for cyberbullying. My mother used to say there is always someone richer, someone poorer, someone skinnier, someone heavier, someone prettier, and someone less attractive than you. If you start down the path of comparison, it will always end in a bad place emotionally, whether you are an adolescent or an adult. Comparison is the root of envy, and envy is at the root of a great deal of depression and anxiety.

The aggression that is part of adolescence has found a new and toxic outlet in social media. It is far easier than ever for teens to attack and publicly shame one another. For teens, sharing their life online can come with added social burdens. Around 40 percent feel pressured to only post things on social media that get them a lot of attention and only show them in a

favorable light. Almost half say they feel overwhelmed by all the drama, and others say that social media sites make them feel worse about their own life..⁶

Disturbingly, as much as 59 percent of American teens report that they have personally experienced online harassment, including cyberbullying..⁷ Ninety percent of teens who report being cyberbullied have also been bullied offline. As most teens use a cell phone regularly, it has become the most common medium for cyberbullying..⁸

Cyberbullying can take many forms:

- Sending mean messages or threats to an email account or cell phone
- Spreading rumors online or through texts
- Posting hurtful or threatening messages on social media or webpages
- Stealing a person's account information to break into their account and send damaging messages
- Pretending to be someone else online to hurt another person
- Taking unflattering pictures of a person and spreading them through cell phones or the internet
- Sexting, or circulating sexually suggestive pictures or messages about a person. About one in five teens have posted or sent sexually suggestive or nude pictures of themselves to others..⁹
- Girls are more likely than boys to have false rumors about them spread by others..⁷

Cyberbullying can lead to depression, anxiety, and even suicide. Once images and posts are on the internet, it is almost impossible to remove them; even if you can have a post or photograph removed, it's likely that someone has a screenshot of it somewhere. Reputations can be ruined; some teens have had to change schools and even move to another town.

Sandra and Kate were feeling overwhelmed and helpless. Their thirteen-year-old daughter, Catherine, was being bullied at school and online by a group of girls at her middle school. Catherine was shy and slightly overweight, with a halo of frizzy hair. She loved art, reading, photography, and being alone. She had little to do with the other girls at her large public middle school, who she thought were immature and focused on their looks, boys, and social media.

Kate told me that the group of girls told Catherine she was “fat and ugly” and called her a “nerd who no one would want to be friends with.” When Catherine did her best to ignore them, the girls started sending group texts about her to the whole school. While the school administration knew what was going on, they did nothing to stop it.

Catherine told her mothers about how she was being bullied and how she felt about it. She also explicitly asked her parents not to interfere for fear it would worsen the situation at school.

Sandra and Kate were furious at the school and worried about their daughter. Sandra, who was a lawyer, thought they should let Catherine fight her own battles. Kate, who was a stay-at-home mom, wanted to protect her daughter from as much pain as possible. They argued over whether to go to the school or to the other parents or to let Catherine handle it on her own.

Through therapy, Sandra and Kate were able to understand that neither leaving Catherine alone nor fighting her battles for her was the right approach; the solution would require a bit of both and Catherine's cooperation.

I suggested that they contact the school and request a meeting with the principal and Catherine's adviser, with the goal of having the school contact the parents of the bullies to let them know what their daughters were doing. I also recommended that, if the cyberbullying continued, Sandra and Kate should contact the police to intervene.

Sandra and Kate agreed that Catherine should get therapy to help her develop her own strong voice to stand up for herself, setting limits on the behavior she would not tolerate rather than passively avoiding the girls when they pursued her. Her therapist also recommended she attend a socialization group monthly.

The principal did speak to the parents of the bullies, and the girls were put on notice that their behavior would not be tolerated; they were put on probation. That sent a clear message to other kids that the school would no longer turn a blind eye to bullying. With the support of her parents and her therapist, Catherine got through the rest of the school year without further incidents.

Bullies Are Kids Too

Bullying is traumatic—that is, it can change the course of emotional development. It might seem obvious that bullying harms the victim, but it also affects the bully. There's a profound disconnect between a bully's actions and their awareness of the impact and consequences of those actions. Bullies are often not aware how harmful they are in the moment, which makes the bullying possible. If they are allowed to get away with their aggressive behavior, it becomes part of their identity; they feel like a “bad” person rather than someone who does “bad things.” It's an important distinction; identity is harder to change than behavior and has a greater impact on mental health. If and/or when a bully wakes up and becomes more self-aware, it can be too late to make amends and can leave them with a heavy burden of guilt.

Bullying has consequences, whether online or in the real world. A middle or high school student could be suspended or expelled from school. If a college or potential employer does a background check and finds relevant posts or other evidence of misbehavior, it could affect their college application or job prospects. If a target has been physically harmed, they could face criminal prosecution.

A cyberbully could be prosecuted for defamation or other harm. Some cases wind up in civil court, with the bully or their parents on the line for financial damages. If posts threaten a person, people, or an institution with physical harm; are of a sexual nature (sexting, sexual exploitation, “sextortion,” or child pornography); or actually result in physical harm to another person, a bully could be prosecuted in criminal court. If the bully is a minor, those charges could be sealed, but if they're over eighteen, those charges, especially if they're convicted of a sexual offense, will follow them forever.

Lars had always been a difficult child, his parents told me. He had been a hard-to-soothe baby, screaming until someone paid attention to him. All his emotions were intense. His mother, Artemis, dreaded taking him out because she could never tell what would set off a tantrum. As a toddler he bit his parents and other children when he was frustrated. When he was two years old, his sister, Tory, was born. Lars acted out his jealousy by throwing toys at his baby sister and pulling the blanket over her head. Artemis, who was a stay-at-home mom, was constantly having to watch Lars to make sure he didn't harm Tory. Lars's father, Christoph, would come home from work to be greeted with his overwhelmed wife's reports of what Lars had done that day. Christoph tried to discipline his son, even resorting to spanking, but Lars's behavior did not change.

When Lars was seven, their pediatrician had unwisely suggested they ignore Lars's bullying and it would stop. It did not; in fact, it escalated. He continued to tease and call his sister names. He would hide her favorite stuffed animal and wouldn't return it until she cried. When his parents weren't paying attention, he would pinch or trip her. They began to get calls from school that Lars had started a fight or pushed a girl in the hallway; he was doing at school what he was allowed to do at home.

By the time both kids were in middle school, Tory was often the target of bullying just as she was at home. Other kids sensed her lack of confidence and vulnerability and took advantage of it.

When Lars was twelve and Tory was ten, Artemis and Christoph came to see me. They were very worried about their daughter, who was clearly withdrawn and depressed. They had recently received a call from the principal, who told them that Lars had punched another boy in the nose and was going to be suspended for three days. They knew they had to do something, but they didn't know what to do.

I explained that without understanding the bully, you cannot help the victim *or* the bully. Tory got her parents' sympathy and compassion, but Lars was the recipient mostly of their disapproval and anger. She was the good girl, and he was always the bad kid. In addition to getting Tory and Lars into therapy, Artemis and Christoph also explored how they could alter the family dynamic to help Lars change his behavior. Christoph realized that his punitive approach to Lars's behavior was essentially bullying, and Lars was repeating that behavior. Artemis had to confront her fear of her son's anger and learn to be present for him, even if the feelings he needed to express made her uncomfortable. Through guidance and training, Lars's parents learned to empathize with him and acknowledge his feelings, while being clear about what kind of behavior was unacceptable. They set appropriate consequences, calmly but firmly.

In individual therapy, Lars came to understand that he was angry at his parents for bringing another child into the family. He viewed his sister as competition for his parents' already inconsistent attention and affection. Afraid to express his anger to his mother and father, he took it out on the most vulnerable and convenient target, his sister. He also learned behavioral techniques for recognizing and controlling his anger.

With her therapist's help, Tory came to understand that her brother's behavior toward her was not her fault and was in fact a way of expressing anger at their parents. She was able to accept that she had done nothing to provoke or deserve it. She was able to stand up to her brother, and eventually to the kids at school. She found that using humor to deflect teasing and jibes was an effective tool and was able to reach out to her parents and teachers for support if she felt she couldn't handle a situation on her own.

You cannot punish away the emotional problems that are at the root of bullying; an exclusively punitive approach only reinforces what your child already believes: “I am a bad person.” Bullies are crying out for help with managing their overwhelming feelings of vulnerability and rage. If you leave them alone with those feelings, it can lead to depression, anxiety, and suicidal ideation, just as with their victims.

Bullies need therapists, and their parents need parent guidance experts. Even the most aggressive bully can learn to understand and turn around their behavior. Only when the adults begin to understand the underlying feelings and motivations for the behavior and get them help can the bullying stop.

Signs Your Child May Be a Bully

Among the indicators that your child may be a bully are

- Out-of-control anger or aggression at home
- Exclusion of old friends, exchanging them for new friends
- Hanging out with more aggressive or behaviorally challenged kids at school
- Emotional outbursts at home
- Getting pleasure from harming another living creature
- Difficulty feeling empathy
- Creating artwork with violent images
- Getting pleasure playing and watching intensely realistic and violent video games

What If My Child Is Being Bullied?

Being bullied in adolescence can shape a child's life and personality. Even for a kid whose parents have given them a good base of emotional security and lots of love, support, and attention, bullying can be traumatic.

According to a 2017 CDC study, students who experience bullying are at increased risk for poor school adjustment, sleep difficulty, anxiety, and depression. Bullying has a negative effect on how kids feel about themselves and their relationships with friends and family, as well as on their schoolwork.² Students who experience bullying are twice as likely as others to experience health issues such as headaches and stomachaches.¹⁰ Of more concern is that students who are bullied are 2.2 times as likely to think about committing suicide and 2.6 times more likely to attempt suicide.¹¹

Signs Your Child May Be Bullied

Indicators that your child might be getting bullied are

- Increased depression or anxiety
- Increased isolation or withdrawal from friends
- Emotional outbursts
- Increased complaints over stomachaches or headaches or desire to skip school
- Loss of appetite
- Sleep disruption or excessive amount of sleeping
- Sudden drop in grades or failure to complete schoolwork
- Body often in a collapsed or shame posture (head down, eyes lowered)

- Inability to make eye contact
- Lying and skipping school

Bullying Prevention

Prevention is the best strategy to avoid your child being either a victim of bullying or a bully. One of the most important factors is a positive sense of self-esteem. Though insecurity is a hallmark of adolescence, kids who are more comfortable in their own skin are more likely to find like-minded friends and have the resilience to deflect teasing and jabs. They're capable of fighting back (metaphorically) if necessary and aren't afraid of coming to their own or another's defense. They are able to find a place in the school's social structure and their own posse to create a safe space.

When your child is going into adolescence and the gladiators' arena of middle school with low self-esteem, they are at a disadvantage. If they are less confident about expressing or asserting themselves, uncomfortable about their appearance, shy or less confident socially, or easily hurt or rejected, their journey is going to be bumpier. It is tempting to let them figure things out for themselves or not involve a helping professional, but if they are a victim of bullying, waiting will only make the problem harder to address as they grow older.

You can help prevent bullying by keeping the lines of communication open, talking to your children about bullying, modeling kindness and respect, and encouraging them to help when they see bullying, are involved in bullying, or know others who need help. Here are some specific ways in which parents can help to prevent bullying:

- Model kindness and empathy at home with each other and with your children; intervene if you see your children bullying each other.
- Model setting boundaries and standing your ground.
- Teach your children not to be bystanders and to intervene to support those who are more vulnerable.
- Be aware of social and peer norms and help your child to fit in as much as possible in terms of style and appearance.
- Help them find their pack: encourage your child to lean into those who lean into them. Help them to acknowledge that not everyone is going to like them nor is everyone going to be their friend.
- Encourage teens to tell you if they are the target of bullying or cyberbullying.
- Create rules and limits around social media and technology use. Initiate conversations about which platforms foster positive interactions and which cause more negative experiences.
- Create and enforce appropriate consequences. Sending mean or hurtful messages or images, or sexting, for example, will result in the loss of phone and computer privileges.
- If your children are under eighteen and living at home, retain access to their social media accounts and review them occasionally.

Communities, particularly school communities, have been successful in preventative strategies. A holistic community plan involves the entire school community—students, families,

administrators, teachers, and staff such as bus drivers, nurses, cafeteria, and front office staff—in creating a culture of respect, kindness, and empathy. We know that prevention works much better than punishment after the fact. A punitive approach can intensify rather than diminish bullying in schools and communities. It requires the community as a whole to support kindness and empathy.

Preventing your child from becoming a bully means creating a loving, secure, and emotionally and physically attentive environment at home. It means being sensitive, empathic, and containing with all emotions, including angry ones. It means not being punitive, but instead trying to understand behavioral issues, academic or social challenges, and providing your child with your nonjudgmental but empathic approach. When your child has someplace to bring their feelings and that place is home, then they need not take those out-of-control feelings to school and project them onto innocent victims.

Intervention When Prevention Fails

Though prevention is best, sometimes intervention is necessary to protect the victim, the bully, and the community. Bullying is ultimately a group behavior, and it takes a group or a community to combat it—that means family, friends, teachers, school staff, and a therapist who are understanding and willing to actively support an adolescent. The mistake many parents make is to assume that kids will be kids and they can handle aggression on their own. Parents getting overly involved in solving the problem for their child can often make things worse. The point is not to do it for or instead of your child, but with your child and the rest of your child's community.

Kids who are bullied reported that support from other kids and adults made a positive difference. The Youth Voice Research Project found that students who were bullied explained that bystanders could take certain actions to make things better, such as

- Spending time with the person who was bullied
- Talking to them
- Helping them to get away
- Calling them later
- Listening and giving advice
- Telling an adult or helping them to tell adults
- Helping them confront the bully
- Least effectively: asking the bully to stop, telling them how you feel, walking away, and/or pretending not to be bothered

The same study found that actions aimed at changing the behavior of the bully (fighting, getting back at them, telling them to stop) were rated as more likely to make things worse.^{[12](#)} The most harmful things to do were to tell the child to solve the problem themselves, tell the child that the bullying wouldn't happen if they acted differently, ignore what was going on, or tell the child to stop tattling.

Students have to be empowered to intervene by parents and teachers when they see a bullying situation. If students believe they can make a difference, they are more likely to act and not be passive. When bystanders intervene, bullying stops within ten seconds 57 percent of the time.^{[13](#)}

People who observe someone being bullied and do nothing are also at risk; being a bystander to bullying is almost as harmful as being bullied. If you watch someone being attacked and do not try to help, you are left with feelings of guilt and powerlessness, as well as the fear that you could also be a victim in the future. Feelings of depression and anxiety among bystanders are not uncommon, particularly if the target is seriously harmed, physically or emotionally.

There is strength in numbers: the most powerful weapon against a bully is having friends or a posse that become your support. The kids who are isolated are most at risk from bullying and have the least leverage against it. If you have a friend or friends who stand up for you in real life or online, then bullies in general back down.

If you are going to get involved, create a multidimensional plan. You can contact the school, the teachers, and the parents of the bullies while your child is rallying friends. Give your child the opportunity to speak with a therapist or counselor. If cost is a concern, some places offer therapy on a sliding scale; the school may also have counseling resources.

Consider whether your child is in the right school. This isn't just an option for affluent families; are there other schools in the area that might be a better fit? Are there programs or extracurricular activities at your child's school that would connect them to kids with similar interests?

Sometimes teachers or school staff won't intervene in a bullying situation. They may be overwhelmed. They may not believe the situation is as bad as your child says it is, or that kids should work these things out by themselves. Bullying rarely gets better and often gets worse. In this case you need to advocate for your child. If the school will not take steps to

address the bullying, you may need to go to the head of the district or school superintendent.

If, in spite of the school's or your intervention, the bullying continues in any form, especially if there has been the threat of physical or sexual violence, you may need to involve the police. Save or print out all emails or texts, save any voice messages, and record calls to use as evidence. You may need to get your child a new phone number, email address, or both.

Bullying is not normal or something that parents should ignore. It can do great harm to an adolescent's emotional health and can impair self-esteem now and in the future. Bullying has always been a problem, and the use of social media and technology has made it more toxic than it was in the past. Taking bullying seriously is just the start. A holistic and multidimensional approach to bullying is necessary to stop the behavior and help your child, whether they are the victim or the bully. Every bully and every victim has an emotional story; our job as parents is to uncover the story that is making the bullying possible. Bullying does not have to be the end point for your child; rather it can be the beginning of an emotional journey toward maturity.

CHAPTER 11

LOOK IN THE MIRROR

Who we are, what behaviors we model, and how we relate to and care for our children impact them and their development more than any other factor. We may not be able to control other aspects of their environment all the time, but we can effect change in ourselves to make our children's lives better.

You are your child's first line of defense against mental health and behavioral issues. If you understand and accept your strengths and weaknesses and continue to learn and grow, your adolescent has the best chance of becoming a healthy and emotionally secure adult.

A Family Inheritance

Parenting is intergenerational: that is, we learn how to be parents from our own parents. If our parents were kind or cruel, supportive and reassuring, or critical and perfectionistic, we are likely to mirror—even unconsciously—all or some of those parenting characteristics and styles. Your children in turn will likely parent their children in a similar way. If we are self-aware, in touch with what caused us pain as children, and prepared not to make the same mistakes with our children that our parents made with us, then we have a chance to change unhealthy patterns of behavior. If, however, we idealize our parents and cannot be objective about what they did and didn't

do well, we will probably repeat whatever mistakes they made raising us.

Putting to sleep our old conflicts and painful unresolved feelings is necessary if we are to parent in a healthy way. For example, if you find that you overreact to a minor infraction of house rules like not putting dishes in the sink or leaving dirty socks on the bathroom floor and mete out a punishment that is disproportionate to the offense, there is usually some unresolved conflict or feeling about your own upbringing and relationship with one or both of your parents that may be coming up at that moment.

For example, if you were afraid because your father would yell at you but could never tell him how hurt, angry, and scared you felt, then when your kid makes you angry, you may blow up the way your father did. Mental health professionals call this *neurotic repetition*: we repeat with our children what was done to us. These are the kinds of realizations that can only come from self-exploration—and often with help from a spouse or a friend, or in therapy.

Your adolescents look to you to understand what it means to be an adult and a parent. Our ability to live an examined life helps our children to live one as well.

You're the Parent

You cannot be your child's parent and their best friend when they are going through adolescence. Your child needs both jobs filled but not by the same person.

It may sound like a good idea to try to act like your kid's friend. You might actually enjoy listening to their music, hanging out with their friends, and wearing their style of clothing as a way to connect, but adolescents, especially

teenagers, need to have separate friends and distinctly different interests and tastes from their parents. It's how they define themselves and establish an identity separate from you. When you intrude too much into their world, it ceases to be separate. This does not mean that you cannot enjoy their music, even if just as a way to understand them. It does not mean you cannot play video games with them or go shopping with them and buy a pair of trendy jeans. It *does* mean that in order to become their own person they need space from you, and you need to give it to them.

Some parents drink or take drugs with their children. This is not a good idea. First, it is against the law to provide illegal substances and alcohol to minors. You could be prosecuted for a criminal offense. It also makes you liable for civil damages if someone is hurt or becomes ill, whether it's at your home or after they leave. Second, it tells kids that it's okay to break the law and the rules of society, which are meant to keep us safe. Third, it breaks down the idea of you as a safe home base.

Parents who try to be friends with their child may have good intentions. They may also have unresolved feelings of conflict over being a grown-up or a parent, and getting older. They may not have had enough of their own childhood before the responsibilities of being an adult were imposed on them. However, when you intrude into your adolescent's world, particularly the world of experimentation, you cross a line that should remain firmly in place. Your job is to provide clear boundaries, clear expectations, a good example, and a framework from which to experiment and, yes, rebel a little. Your adolescent still needs a parent who is a reliable, emotionally safe harbor, and who will help them navigate acceptable and unacceptable behavior. They need you to say no or be the excuse for them to say no when they're confronted

with uncomfortable, risky, or even dangerous situations. Only by knowing what is right based on your own actions and behavior can they be expected to mature and develop good judgment and learn right and wrong.

Kids have an unerring BS sensor; you can't say, "Do as I say," and not do it yourself. My father used to say, "Words are cheap; it's actions that matter." If your own behavior, lifestyle, and actions do not match what you expect of your adolescent, don't be surprised if, no matter how much you lecture them, they behave like you. If you smoke or drink heavily but tell your kids to avoid drugs and alcohol, don't be surprised if they smoke or drink. If your relationships aren't supportive and nurturing, but you expect your child to have healthy ones, think again. If you criticize your own appearance, complain constantly about your weight, or are obsessive about what you will and will not eat, don't be surprised if your child has issues around eating and body image.

The traits and behaviors discussed in the rest of this chapter need to be cultivated in order to parent your adolescent successfully.

Your Self-Esteem Matters

How can parents expect their children to have good self-esteem when they do not feel good about themselves? Parents who do not feel secure and constantly seek reassurance from their children that they are valuable and loveable put an extraordinary burden on those kids. These parents are not modeling positive self-worth. If we are perfectionists or harshly critical of ourselves, it models that kind of perfectionism for our children. Harshness and perfectionism are self-hating behaviors that can be passed down from parent to child. When

we focus on the surface or appearance rather than our internal goodness, we pass this self-consciousness and insecurity on to them. When we love ourselves, our strengths and weaknesses, our limitations as well as our capabilities, we model good self-esteem. Being a parent requires that we be our best selves, which does not mean we have to accomplish or achieve great things, because the greatest accomplishments we show our children are our attention, love, and understanding.

Emotional Stability

If we yell, if we go from zero to sixty in three seconds in anger, if we have outbursts of rage or hysteria, if we are manic or suffer from intense anxiety or depression, this is the model for how our children will learn to handle their emotions. If you respond to frustration with impatience and intolerance, your children also will. Don't be surprised when your child cannot complete tasks at school when they have experienced you having difficulty with patience and follow-through at home.

Many parents come to see me for guidance because their own emotional volatility reminds them of their parents' volatility, and they do not want to repeat the same way of interacting with their own children. Emotional regulation means you are able to keep your feelings from going too high or too low. It does not mean that we are numb to feelings, but that we can process or metabolize them and get ourselves back to an emotional balance without harming ourselves or those around us. It means that we can think about our emotions before we blurt them out or act on them and can remain calm and thoughtful even in the face of situations that frighten, frustrate, or anger us. When we do experience feelings of anxiety or depression, or have unresolved conflicts or emotional volatility,

the burden is on us as parents to get help so that we do not expose our children to our emotional regulation issues that they may then inherit.

Stan and Faye were tired. They had been called into school to discuss their son's behavior for the third time this semester. Now fifteen years old, PJ had always had problems controlling his temper and fighting with other children. When PJ was six, his behavior became such an issue that Stan and Faye took him to a psychiatrist, who prescribed medication for ADHD to help him moderate his impulsive behavior and anger. The medicine did help PJ, but as he got older he refused to take it because he said it made him feel nervous and disconnected.

Without the medication, PJ could not control his explosive temper. He was almost six feet tall and weighed 175 pounds, and while he hadn't hurt anyone seriously yet, they were afraid it was just a matter of time.

In working with Stan and Faye, it became clear that they both had issues with emotional regulation. Stan would blow up regularly, yelling, threatening to leave the family, occasionally throwing or breaking things, and walking out of the apartment. During these episodes, Faye would be compliant and submissive as a way to calm Stan down. Exhausted and depressed, after these episodes she would retreat to her room, leaving PJ to fend for himself. PJ was often present for his father's outbursts; frightened by his father's anger, as a child he would hide under the kitchen table or in a closet with a few of his toys.

This emotionally volatile environment was PJ's normal. Faye and Stan had no idea that their own difficulty managing and dealing with their emotions had impacted their son. When they came to me, I strongly recommended that each member of the family go into individual therapy: Stan to be able to manage his rage, and Faye for her depression. PJ's therapist was a man who showed PJ a different model of appropriate male behavior. In therapy PJ learned to express his feelings of fear and sadness at his father's outbursts and his feelings of loneliness because of his mother's depression. He acquired coping techniques, including progressive relaxation and breathing, which worked to calm him and center him when he felt a full-blown tantrum coming on.

The family adopted a calm, loving rescue dog, Henry; PJ was responsible for taking care of him. Henry acted as an emotional support dog for PJ and accompanied him everywhere he was allowed. They got him stress balls and a standing desk for his room, which made concentrating on his schoolwork easier.

Stan and Faye requested a conference with the principal and PJ's guidance counselor and teachers. They explained that PJ was getting help with his regulation issues and suggested that they work together to create a plan to consolidate and maintain his progress. They agreed that if PJ was feeling overwhelmed in class he could signal the teacher and sit in the guidance office until he calmed down. He would sit near the front of the class so he would be less distracted by the other students. Instead of a free period, he would visit with his guidance counselor to talk about his day.

The most important change was for Stan and Faye to become more self-aware of how their own emotional issues had impacted their son. His parents' increased attention and empathy and support system worked together to form a loving circle of

help rather than judgment and punishment around PJ, who slowly improved in regulating his impulses and aggression.

Limits and Flexibility

Parents confuse structure with strictness and often feel that setting harsh limits is good for their kids. In fact, setting strict and harsh limits is as detrimental to children as not setting limits at all. The effect on children can be the same: a feeling of emotional neglect, perceived rejection by their parents, or helplessness.

Moderate and flexible limits are helpful. When we are rigid, we create rigid and sometimes anxious children. The strongest ego is one that can yield when necessary. Think of a tree in a storm: when the tree is made of hardwood, the first harsh gust of wind breaks its branches. A branch made of softer wood blows in the wind but does not break. That is the definition of resilience.

Flexibility also implies our ability to grow and learn as we age. Parents who are inflexible in their ways and their thinking often cannot listen to or learn from their kids. When we are willing to hear what our children have to say when they think we are unfair or that we may not understand them, we may learn something new about our children and ourselves.

Peter, sixteen, had just received his driver's license. He had agreed to his parents' rule that he could not drive without an adult in the car, and for several months he complied. One day he came home from school and realized he forgot to bring his computer. His mother was at work, and his father had gone out for a run with the dog. Peter grabbed the car keys and drove back to school to get his computer. When he got back his father was waiting and was furious. He yelled at Peter and punished him by taking away his driving privileges for a month. When his mother came home, Peter appealed to her, but she sided with his father. Peter felt his parents didn't understand how desperate he felt about finding his computer and that they should have made an exception to the rule. He retreated to his room and would not speak to his parents for

the rest of the day; for the next several days when he did speak to them, he was sullen and distant.

Peter's mother, Jane, called me for help. I worked with her and her husband, Paul, to better understand what had triggered Peter's mood change. Jane and Paul wanted to be close to their son and didn't understand what they had done wrong. I explained that Peter had only broken the rule because he was afraid his computer could have been stolen and hoped his parents would have understood that he hadn't done it without a good reason. By enforcing such a harsh penalty for a relatively minor infraction, they had shown a lack of faith and understanding in their son. It turned out this wasn't the first time Jane and Paul had overreacted when Peter made a mistake or misbehaved. There was never a discussion, nor were there the openness and flexibility to allow them to see that exceptions could be made in certain circumstances.

Jane and Paul sat down with Peter and asked if they could hear his side of the story about the car. When he was finished talking, they told him that they understood why he made the decision he did and apologized for rushing to judgment and not listening more carefully. They said that while he could have and should have waited the few extra minutes for his father to return, they understood why he made the decision to drive to school. They restored Peter's driving privileges and made an effort to listen and be thoughtful when they needed to use discipline in the future.

Self-Discipline and the Ability to Say No

Setting flexible and moderate limits makes children feel safe and loved. It is also important to set limits and boundaries with others and say no when you mean no. We cannot be emotionally healthy and have healthy relationships without boundaries. We cannot respect ourselves or others without setting limits with those we care about.

If we are emotionally insecure, afraid of, or self-conscious about how others may think or feel about us, or if we are too afraid of losing someone, we may have trouble setting limits on what kind of behavior we do or do not tolerate. Saying no means we risk making others angry with us; it is our ability to accept and handle that anger or frustration that is necessary to have honest and intimate relationships. When we tolerate unacceptable behavior or emotional abuse—or when we never say no to our children, our spouse or partner, our extended family, or our friends—we show our children that we are

uncomfortable with others' anger and disapproval, and that their feelings are more important than our self-worth.

Patience

Patience is a virtue indeed, particularly when raising adolescents. It may be the most important characteristic of a good-enough parent. Can we stay calm in the face of challenges or frustration, or do we erupt and become defensive or angry when our children defy us, disagree with us, or disobey us? Can we contain our reactions enough to help them contain theirs? Patience is not something we are born with; we learn to be patient when our parents are patient with us. If our own parents were impatient and easily frustrated, and had a short fuse, then we are more likely to be that way with our children. It is important to understand our history if we want to disrupt that cycle.

If we are impatient with others, it usually means we never learned to be forgiving of our own mistakes and failures. If we cannot forgive ourselves, it is that much harder to forgive our children.

Resilience to Stress

Parents are resilient to stress when they feel emotionally secure and have the inner resources to soothe themselves in times of adversity and distress. Resilient parents have a greater chance of passing that quality to their own children.

I like to use the story of the three little pigs to explain resilience. If you are raised with an emotionally healthy, sensitive, and empathic parent who was able to identify, reflect, and soothe your feelings of distress when you were upset, you grow up like the little pig who built the house of bricks; when

the big bad wolf (disappointment, emotional pain, adversity, stress, illness, loss) huffed and puffed, the house stayed intact and strong. However, if you were raised with parents who dismissed or ignored your feelings of distress or did not comfort you, then you are more likely to be like the little pigs who built a house of hay or twigs, and your house will collapse when the wolf blows.

Neuroscience research is very clear: empathy and sensitivity are the keys to healthy attachment and to raising mentally healthy human beings. Our empathy, the ability to feel for another person and to relate to feelings of all kinds—or our lack of empathy—casts a long shadow over our children.

When we are insensitive or emotionally shut down—or worse, dismissive—we reject the very vulnerable souls we have brought into this world. If we struggle with empathy toward our children, how can we expect them to feel for those closest to them in the future, not to mention addressing a world full of problems?

Empathy is also the basis of self-esteem, and the key to good self-esteem in children is their parents' emotional sensitivity. When you recognize and validate your child's feelings, you recognize them as a valuable human being.

When we recognize our children's pain, we model recognizing others' pain for them. If we model empathy toward those less fortunate than we are, whether a local homeless man, the neighbor who lost her husband, the victims of a hurricane, or the puppies in the shelter—we model extending our empathy not only to those closest to us but to our community as well. It is through giving to others in pain that we feel better about ourselves, and this is what we give to our children when we are empathic parents.

Interdependence and the Capacity for Intimacy

Our culture seems to overvalue self-sufficiency and independence. However, *interdependence* rather than *independence* should be our goal. Needing the love and support of others and having the ability to turn to them when we are in distress are critical for our emotional well-being, as is the ability to comfort ourselves. Those who cannot ask for help or turn to others isolate themselves and are destined for a lifetime of loneliness and struggle in their intimate relationships.

When your adolescent was a baby, they turned to you to comfort and to soothe them when they were in distress. It may be hard to tell by the way they act, but your adolescent kids still *do* need you. In fact, one of the biggest mistakes parents make is to react to their kids' testing their authority and asserting their own independence by flying the coop themselves. It's like driving a stick shift: the only way to release the clutch is to gently press down on the gas. If you floor it, the car may stall.

Here's the truth: teenagers and young adults may say they don't want your company, advice, or help, but this is part of their struggle to separate from their families and shape their own identity in the world.

Teenagers in particular need their parents' physical as well as emotional presence. They want to know that you're thinking about them and their needs. Like toddlers testing the limits of being away from the security of their mother's body, you are a secure base from which to launch, refuel, and launch again. This is why the adolescent researcher and clinician Peter Blos labeled adolescence the "second individuation," the second go-round of separation and identity formation.¹

Communication Skills

Open communication is one of the most important characteristics of a healthy relationship with your adolescent. If we are not comfortable expressing our feelings and thoughts openly with those closest to us, we cannot model this way of interacting with our children. Communication is critical at all stages of a child's development but never as important as when your kids are going through adolescence. There is so much conflict, change, struggle, and turbulence in their lives that without the ability to express their thoughts and feelings, they can become isolated, depressed, and even suicidal. They are more likely to engage in self-destructive behavior.

The challenge for parents is to be open to the full spectrum of their adolescent's emotions. You may have been raised by parents who valued only "happy," "positive," or "good" emotions. This was a mistake. Emotions such as anger, sadness, frustration, confusion, rejection, and abandonment are as important as happiness and excitement. Being able to feel, express openly, and accept all emotions as "good" and valuable is essential to mental health. When we label emotions as good or bad, positive or negative, we make certain emotions taboo or unacceptable. It is often hard for parents to feel their own painful emotions, let alone their children's painful emotions, but this is what the job of parenting entails.

If you have difficulty or are uncomfortable with some emotions or subject matter, then your adolescent will not turn to you when they need you. They may turn to other adults or their friends, and you will have lost the opportunity to maintain a close connection with your child. Others your child may turn to may not share your values. Worse still, your child may not be able to express their emotions to anyone. If your child does not have good friends or has social challenges, then they are truly alone. I often encourage the parents to see a therapist to learn

to connect with, express, and accept their own intense emotions so that they can help their children express and accept theirs.

Amy, sixteen, ran with a fast crowd in high school. The kids she hung around with were experimenting with drugs and alcohol, and most of the couples were having sex. Amy liked being in control, so while she occasionally drank or smoked a joint, she was never drunk or so stoned she couldn't function, unlike some of her friends. There was no one she was particularly attracted to in her group, and she didn't feel the pressure to hook up.

Amy felt conflicted about her friends; she liked them but not their behavior. She was afraid that if she talked to her friends about their behavior, they'd stop including her. She used to confide in her parents but knew if she spoke to them about her feelings, they would punish her and try to forbid her to see her friends. She felt quite alone. I asked Amy for permission to speak to her parents; she agreed, although with a great deal of trepidation.

When I spoke with Joanne and Aaron, they were shocked to hear that their daughter didn't feel comfortable speaking with them; they had always thought of themselves as open and accepting. They hadn't realized that they were open to Amy expressing the "good" things about school and her social life but didn't really want to hear anything that would disturb their image of their daughter as a "good girl." By working with me in therapy, Amy's parents learned to practice listening more than speaking, as well as listening objectively and without judgment.

Joanne and Aaron applied this new way of interacting with their daughter to other subjects like sex and picking a college. Both were subjects Amy had avoided bringing up because her parents would either shut down the discussion or overreact and Amy would retreat to her room. Once she trusted that her parents were willing to listen to her without blowing up, she was willing to share more details of her life with them and take in their suggestions when she asked for them.

Letting Go

Our ability to allow our adolescent children to separate from us and become their own individual selves is as important to their mental health as loving them with all of our hearts. Separation is not usually associated with nurturing because we think of the sweetness of our babies' and young children's dependence on us as the definition of nurturing. In fact, attaching and separating are both forms of nurturing. Allowing our children to be dependent upon us physically and

emotionally in the first three years of their lives is the critical foundation for their independence from us as healthy adults.

Perhaps you've read the quote "Good parents give their children roots and wings: roots to know where home is, and wings to fly off and practice what has been taught to them." All children need a sense that they have some control and independence; it's why toddlers favorite word seems to be "no." The older the child, the more control they need over their decisions, whether it's deciding to continue to play soccer or where they want to attend college.

As your child begins to make their own choices, let them know that you trust their judgment, but that until they are legally responsible for themselves, yours is the final word on issues of their health and safety. Having faith in what you have given them in the past and in your adolescent's inherent goodness and competence is part of their belief in their own goodness and competence. Learn to pick your battles, as you did when they were toddlers. Micromanaging every aspect of their lives isn't good for them or you. An anxious helicopter parent may produce anxious and fearful children.

Parents commonly struggle with the differences their children may express about their beliefs, interests, lifestyle choices, friends, and meaningful work. Ask yourself, Are you comfortable with your child's burgeoning individuality and independence? Do you accept their newfound freedoms, or do you try to block them from making their own decisions about their lives? Do you accept their exploration and experimentation in the world, or do you try to keep them excessively dependent on you or helpless? It can be hard to accept that your children are *of* you but *not* you. It can also be hard to accept their separateness if you fear you will be lonely, or you worry about your own identity other than as a parent.

Freud said you need love and meaningful work to be emotionally healthy. In the early years of parenting, love may *be* our meaningful work. However, as our children age and need us in a different way, it becomes important to keep developing yourself and your “meaningful work” so that you may let them go on their healthy way toward a future of their own.

Adolescents need to feel that their parents will be okay without them when they leave so that they can build their own life. When children start to express their need for more space, it is a perfect opportunity for parents to carve out more space for themselves and refuel an emotional and romantic connection to their spouse or partner. It is also an opportunity to reconnect with friends and give more attention to work and outside interests.

Caring for Yourself

Parenting is hard work. If your inner resources are depleted, if you are stressed and crowded for space of your own, you cannot be there for your adolescent child. Caring for yourself—getting enough sleep, eating well, exercising, spending time with your friends, and doing things that give you pleasure—is critical to your own mental health so that you can be the best parent you can be.

Modeling caring for yourself also models balance for your children. If they see you run yourself into the ground with work, if you are stressed because your work/life balance is out of control, your children will follow suit in their own lives. If, however, you take time and space for relaxation and self-care as a respite while caring for others, that will be their model.

Don't Be Afraid to Ask for Help If You Need It

Individual, couples, or parent guidance therapy can help parents become more reflective about themselves and their children. When we observe aspects of ourselves in our children that we do not like, it is time to look in the mirror. Doing it alone may only solidify defenses that have protected us from change for many years. However, when we look at ourselves in the presence of a mental health professional who is trained to see us differently, we can change our direction and behavior. The burden is on us to work on ourselves to benefit not only ourselves but our children and the generations to come.

At some time in your adolescent's life, they would likely benefit from the help of a professional. If they see that you accept help and support, it removes any stigma around depending upon others. If you are open to help, they will be too—if not now, then in the future.

If you rely only on symptom relief and medication, as opposed to self-examination and exploration of feelings and thoughts on a deeper level, then do not be surprised when your children do not have the capacity to understand their deeper motivations and reasons for their pain.

Parents are works in progress, just like their children. To be humbled by the experience of parenting is to be open to change. If you are defensive about your flaws or imperfections, your children will never learn how to accept and work on their vulnerabilities. Parenting is not about perfecting yourself, just as it is not about perfecting your children. It is about continuing to grow and model how growth is not something that ends with adolescence.

CHAPTER 12

IT'S NEVER TOO LATE

Redefining Your Relationship and Repairing Old Hurts

Parenting is the most selfless role most of us will ever play in life. It is also one of the hardest roles because it demands so much of us. We are not perfect; sometimes we lose sight of what is important or we are not our best selves. We make mistakes and say hurtful things to our children that we wish we could take back. We make judgment calls we are not proud of and lose our tempers.

Sensitive, empathic caregiving—being aware of your child's physical and emotional needs, understanding and responding to their verbal and nonverbal cues, and responding appropriately and consistently—is the gold standard for parents, whether they are raising a two-year-old or a fifteen-year-old. It is our emotional and physical presence as well as our sensitivity to the dance of connectedness and separation that builds a foundation of mental health.

Many parents I see regret not spending more time with their kids when they were small or not being emotionally present when their children needed them most. Some parents were overwhelmed by their responsibilities or preoccupied with their careers, or suffered from depression or anxiety. There are mothers who suffered from postpartum depression, and some

parents were physically ill. Some just may have been ambivalent about parenting.

In addition to their own distress about missed time or challenges in their parenting style, they may see signs of stress in their children. The hopeful message I have for parents is that they can still rewrite some of the script so that it has a different ending for them and their child.

In fact, it is never too late to improve or repair your relationship with your child. Between ages nine and twenty-five, the adolescent brain is pruning and rewiring itself, which gives you a chance to be involved in a healthy way, to try to understand them, and to get emotionally close to them before they leave for college or to live on their own, when developing closeness becomes more challenging. The ability to love and let your children become independent adults—and repairing the damage done in between—is the foundation of resilience and emotional security. It is the greatest gift you can give to your child, and despite what some people may think, adolescence is the perfect time to bestow it on them.

As with all emotional repair, it is best to address a rupture or damage as soon as possible. When you get a hole in your sweater, the sooner you can have it repaired, the less likely it is that the hole will get worse. Sometimes, the mended part of the sweater is even stronger than the rest of the fabric.

Admit You Were Wrong

Repair starts with self-awareness and taking responsibility for your words and your actions.

In all my years as a therapist, I've seen that the most painful thing for my patients is when their parents did not understand, accept, or take responsibility for their hurtful words and

actions. Even as adults they may feel alone, unrecognized, and unimportant. Their parents' disregard or dismissal of their feelings made them question the validity of their experience, their judgment, and themselves. The same is true for your children.

It is hard to accept responsibility and admit we may have hurt our children. When we are brave and emotionally secure enough to sincerely say we are sorry, we model for our children how to own our mistakes and how to be intimate with another human being. When we become defensive in the face of our adolescent's criticism or complaints, we make it all about us and not them. We stop listening, and listening is the key to understanding.

Being There When the Door Opens

There is no substitute for time spent with your children, no matter what their age. Time creates opportunities for emotional refueling and reconnection, and it also gives you the space to discuss and resolve conflicts, whether they're old or new.

Spending quality time is lovely in theory, but the reality is that teens and young adults want you when they want you; you're parenting on their time, not your time. They may be home less frequently, but the more you're both there at the same time, the more likely it is you'll be there when they're ready to talk, whether it's about how hard the history test was or how you embarrassed them in front of their friends. You have a better chance of having a real conversation when they pop their heads out of their room to get a cookie while you're cleaning up after dinner or while you're driving them to soccer practice than trying to talk when you come home from work and you want to "optimize your quality time." Bedtime is a time

we are tired, our emotional defenses are down, and we feel most vulnerable. We're more likely to be open and reveal what thoughts and feelings have been lurking beneath the surface. I've found it's one of the times my children are more likely to tell me what's been on their minds or what's been bothering them. If this is your experience too, don't rush away; take the time and opportunity to hear what they have to say. You may be surprised.

You need to be there when the door into their private world swings open, and they're ready to let you in. If you're not, the door will close again.

Everyone Needs a Hug

Your children will never be too old for a hug, and it is never too late to be affectionate with them. Hugging, holding, touching, and kissing a loved one (if and when they will let you) doesn't just feel good; it reduces stress hormones. I've heard many parents complain that their teenagers brush them off when they try to hug or kiss them, but if you're patient, you'll find your teen still wants affection. It's just that their desire for contact is different from yours. If they won't accept a big hug, they may tolerate your straightening their collar, or what a friend of mine calls *the lean*.

Timing is important too; I've found that my kids will sit close and accept an arm around their shoulders when we're watching TV but may resist my affection when we are walking down the street. If they reject your attempts or brush you off, try not to take it personally or as a rejection. Let them come to you when they are ready. Adolescents struggle with wanting and often needing your warmth and physical affection while

feeling that desire compromises their struggles to separate from you.

Be Willing to Learn and Grow

As long as we are alive, we can grow emotionally. Even adult brains have plasticity, which means they can continue to physically grow and change. Seventy-five years ago it was common for psychoanalysts to refuse to see patients over the age of forty because it was thought that the brain is fixed and unchangeable after a certain age. Neuroscience research today shows that this is not true.

When we recognize that we have room to grow and are willing to get help to do so, we show our children that there is always room to grow and change themselves. We model that, although imperfect, we are also works in progress.

Some Things Can't Be Rushed

Repair takes time. The best outcome of changing how you relate to your child is a deeper emotional connection and more frequent sharing of thoughts, feelings, and experiences. Perhaps your parenting style was more “spare the [metaphorical] rod, spoil the child,” or you valued discipline, independence, and the proverbial stiff upper lip as the most important attributes rather than emotional sensitivity, empathy, and understanding. If you adjust or even radically change your parenting style, your child may not trust this new you right away. They may even think you are trying to manipulate them. This is a time for honesty and openness on your part. If you can tell your children that though you know you aren't perfect, you are working to do better, your kids will give you the benefit of the doubt.

Get Comfortable with Uncomfortable Emotions

Not all emotions are comfortable ones, particularly when it comes to parenting. You may be uncomfortable with anger, sadness, vulnerability, dependency, or need, and you don't allow yourself to feel—and maybe even ignore—these emotions.

Happiness is not a constant state of being. If you expect to always be upbeat and happy, then anything else feels like a failure or incomplete. An emotionally healthy human being is not happy all the time; this would be both exhausting and impossible. Think of it like riding a roller coaster: you may be scared or uncomfortable much of the time, but that makes the exhilarating bits all the more appreciated. An emotionally healthy person feels the full range of emotions, including deep sadness and anger, and is able to regulate their emotions back to a state of balance.

Adolescents are unhappy much of the time. You might say that this is their natural state of being. They may feel all emotions intensely and often express them impulsively, but they are rarely happy. If you judge your child's mental health on how happy they are much of the time, then you will often feel like a failure as a parent. Imagine your role as a parent of an adolescent to be like the person who sits next to your child on the roller coaster: someone to hold their hand as they go through the ups and downs.

In our culture, the default is to get rid of uncomfortable feelings rather than express them, let our children express them, or mourn the losses or challenges we face. It has become such a national obsession that half of America is on some kind of psychotropic medication for feelings that involve loss, sadness, loneliness, and anger. When you repair earlier

misunderstandings or conflicts with your child, you are often repairing the dismissal or denial of important feelings and experiences. Our message to our children needs to be that we are okay with whatever feelings they express, including their sadness, despair, and even their rage.

Change Is Not Easy

Changing the way you interact with your child is not easy, but as I say to my kids, nothing worth having or doing is really easy. You may do your best to be more present and available to your child and revert back to the old ways of speaking to them and relating or not relating. You may scream or be judgmental when you need to be empathic, or punish when you should be listening and asking questions. You may hear yourself sounding like your mother or father in all the ways you told yourself you would never do.

It is normal to struggle when you learn anything new; all new skills require a lot of effort before they come naturally. When I learned to ski as an adult, I had to think about the correct position and how to use the poles to guide me. Then one day I realized I was skiing down the mountain without having to think about how to bend my knees or when to use my poles. I was able to enjoy the ride without the hard work of having to remember every detail. That is what it will feel like when you have mastered change in relating to your adolescent.

Old Patterns Die Hard

Patients often ask me why they repeat painful behaviors or relationship dynamics when they consciously know they are painful. I will tell you what I tell them: we are taught from birth to become used to and familiar with how to interact with

others. If we are, as John Bowlby, the father of attachment theory, teaches, vulnerable to and subject to the emotional and relational scaffolding our parents set for us, then we repeat what we know. If we are taught that love means pain, then we are drawn to pain.

We also repeat these relationship patterns and experiences to try to change the ending of the story. The problem is that we usually do not change the ending because the behaviors are *unconscious* and thus not within reach of our self-awareness. Freud wrote, “Repeating is remembering,”¹ which means that although we may not remember much of childhood in memory, we can often rely on our behavior, words, actions, and interactions with our own children to tell us about our own history. This is why I recommend talk therapy, which makes our unconscious behaviors, feelings, and motivations conscious to us so that we may truly change the ending.

Lastly, when we repeat these behaviors, we put ourselves in the position of control rather than that of the victim. When we are children we are a captive audience; we cannot change our situation. When we have children of our own, we are in control. All these complicated experiences and feelings tie us to our own children and tie our children to our experiences with our own parents.

If we are aware of our family dynamics, we can avoid repeating the same negative patterns of behavior with our children, but we can also pass on the warmth, nurturing, generosity, connection, empathy, sensitivity, and affection that were given to us.

The Choice Is Yours

The only thing standing between you and being close to your child is you. Changing the relationship with your child is possible if you truly want to do it. This is easier if they are still living at home, but even if they are independent adults, it is still possible. You never know how close you can be to your child unless you try.

During my years as a therapist, it has been my experience that children who have had a painful or unsatisfying relationship with their parents always wish and hope for a new understanding. You need only imagine how satisfying it would be if you could, or could have, changed the relationship with your own parents to understand how satisfying it is to your adolescent child if you try to make your relationship more connected and stronger. No one is perfect, and perfect is not the goal—only better and better.

Resources

Chapter 3: Understanding the Adolescent Brain

The Adolescent Brain for Teens: <https://www.heyigmund.com/the-adolescent-brain-what-they-need-to-know/>

Chapter 4: Gender and Sexual Identity

Centers for Disease Control and Prevention LGBTQ resources for youth and their families: <https://www.cdc.gov/lgbthealth/youth-resources.htm>

Advocates for Youth parent resource (multilingual): <https://advocatesforyouth.org/resources/health-information/are-you-an-askable-parent/>

PFLAG, online resources and community for families: <https://pflag.org/family>

Gender Spectrum, online resources and community for families: <https://www.genderspectrum.org>

Human Rights Campaign, resources for parents of transgender children: <https://www.hrc.org/resources/supporting-caring-for-transgender-children>

Family Acceptance Project: <https://familyproject.sfsu.edu>

Resources for talking about teen dating and sexuality: <https://www.healthychildren.org/English/ages-stages/teen/dating-sex>

Chapter 5: Anxiety and Depression

Substance Abuse and Mental Health Services Administration (SAMHSA) National Hotline/Treatment Referral Routing Service: 1-800-662-4357 (HELP)

Substance Abuse and Mental Health Services Administration (SAMHSA) National Hotline/Suicide Prevention Lifeline: 1-800-273-8255 (TALK)

Crisis Text Line: text “HOME” to 741741

Suicide prevention for parents: <https://www.helpguide.org/articles/suicide-prevention/suicide-prevention.htm>

National Alliance on Mental Illness (NAMI) Family Support Group: <https://www.nami.org/Support-Education/Support-Groups/NAMI-Family-Support-Group>

Teen depression, resources, and tips for parents: <https://www.helpguide.org/articles/depression/parents-guide-to-teen-depression.htm>

National Alliance on Mental Illness (NAMI) tips for parents of children with depression: <https://nami.org/Blogs/NAMI-Blog/December-2018/5-Things-You-Can-Do-to-Help-Your-Child-with-Depression>

Balanced Mind Parent Network, online community: <https://www.dbsalliance.org/support/for-friends-family/for-parents/balanced-mind-parent-network/>

Chapter 6: ADHD, Learning Issues, and Social-Developmental Disorders

Help guide for parents of children with ADHD:
<https://www.helpguide.org/articles/add-adhd/when-your-child-has-attention-deficit-disorder-adhd.htm>

Help guide for parents of children and adults with ADHD: <https://chadd.org/for-parents/overview>

ADDitude magazine, online: <https://www.additudemag.com/help-teen-manage-adhd/>

Meditation for teens with ADHD:
<https://www.headspace.com/blog/2017/07/08/meditation-and-adhd>;
<https://redmountaincolorado.com/blog/guided-meditation-practice-improves-focus-for-teens-with-adhd> <https://positivepsychology.com/mindfulness-for-children-kids-activities/>

Understood, resources for families:
<https://www.understood.org/pages/en/families/learning-thinking-differences>

Aspiro, resources for families: <https://aspiroadventure.com/blog/learning-disabilities-teenager-young-adults/>

The Asperger/Autism Network, parenting advice: <https://www.aane.org/tips-parents-teens-asperger-syndrome/>

Interactive Autism Network, on screen time: <https://iancommunity.org/teens-and-screens-resources-parents>

Individuals with Disabilities Education Act (IDEA), federal law and regulations:
<https://sites.ed.gov/idea/>

Chapter 7: Disordered Eating and Eating Disorders

National Eating Disorders Association helpline: 1-800-931-2237

Crisis: Text “NEDA” to 741741

Chat online: <https://www.nationaleatingdisorders.org/help-support/contact-helpline>

National Eating Disorders Association, Parent Toolkit:
<https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/ParentToolkit.pdf>

Understanding eating disorders in young women:
https://youngwomenshealth.org/wp-content/uploads/2014/10/Eating-Disorders_Parent_Guide_2019.pdf

F.E.A.S.T., for parents of children with eating disorders, online community:
<https://www.feast-ed.org/what-is-feast/>

Eating Disorders Anonymous: <https://eatingdisordersanonymous.org>

Eating Recovery Center:
<https://www.eatingrecoverycenter.com/families/portal/resource-center/family-support-guidelines-when-your-loved-one-has>

Chapter 8: Drugs, Alcohol, and Vaping

Understanding substance use: <https://www.healthychildren.org/English/ages-stages/teen/substance-abuse/Pages/default.aspx>

Substance Abuse and Mental Health Services Administration (SAMHSA), parent resources for substance use in teens: <https://www.samhsa.gov/underage-drinking/parent-resources>

Parent toll-free helpline: 1-800-378-4373

Chapter 9: Technology, Social Media, Gaming, and Gambling

ScreenStrong, helping families address technology use: screenstrong.com

National Council on Problem Gambling helpline: 1-800-522-4700

Chat: ncpgambling.org/chat

Gam-Anon meeting list: <https://www.gam-anon.org/meeting-directory/us-meeting-directory>

How to talk to your child about gambling: <https://preventionlane.org/gambling-youth-tips-parents>

How to talk to teens about sex and sexual risk-taking:
<https://advocatesforyouth.org/resources/fact-sheets/parent-child-communication-programs/>;
https://www.cdc.gov/healthyyouth/protective/factsheets/talking_teens.htm;
<https://health.gov/myhealthfinder/topics/everyday-healthy-living/sexual-health/talk-your-kids-about-sex>

Chapter 10: Bullying and Social Media

Stop Bullying resource guide: <https://www.stopbullying.gov/resources/get-help-now>

Cyberbullying resource guide: <https://cyberbullying.org/resources/parents>

Facts and advice: <https://www.internetmatters.org/resources/social-media-advice-hub/>

Protect teens on social media: <https://www.safesearchkids.com/parents-guide-to-protecting-teens-on-social-media>

Teen social media use, Q&A for parents: <https://www.common sense media.org/social-media/age/teens>

General Mental Health Resources for Parents

National Institute of Mental Health (NIMH), “Children and Mental Health”: <https://www.nimh.nih.gov/health/publications/children-and-mental-health/index.shtml>

National Institute of Mental Health (NIMH), “Information and Resources for Family Members and Caregivers”: <https://www.nami.org/Your-Journey/Family-Members-and-Caregivers>

National Institute of Mental Health (NIMH), “Seeking Psychotherapy”: <https://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml>

Finding a Psychoanalyst or Psychotherapist

American Psychoanalytic Association: <https://apsa.org>

International Psychoanalytic Association: <https://www.ipa.world/>

Substance Abuse and Mental Health Services Administration (SAMHSA), National Directory of Mental Health Treatment Facilities 2020: https://www.samhsa.gov/data/sites/default/files/reports/rpt23266/National_Directory_MH_facilities.pdf

Appendix

A Note About Psychiatric Medication

Psychiatric medication is an important tool in treating certain forms of mental illness. However, medication is not a panacea. In fact, we're not exactly sure how and why these medications work. They should almost never be used as a first-line treatment except in case of an emergency, nor should they be continued indefinitely. A child or adolescent should only be prescribed psychiatric drugs by a psychiatrist specializing in children and adolescents. A pediatrician or adult psychiatrist should not prescribe psychopharmacological medication for your child.

Medicating with psychopharmacological drugs is not a one-size-fits-all process. This is true for treating adults as well as adolescents. It's a little like throwing spaghetti against the wall and seeing what sticks. "Does this one work? No? Let's try another." Doctors are increasingly using genetic testing to determine which class of drug may be right for your child. This can reduce some of the trial and error of prescribing these drugs. With some conditions—seizure disorders, anorexia nervosa, bulimia, drug withdrawal—certain medications are contraindicated.

Many psychiatric drugs are available in generic form. While generics are less expensive, there is some debate about whether they are as effective or reliable as their brand-name equivalents; while the active ingredient in these drugs is

chemically identical, the medication delivery system and other inactive ingredients differ by manufacturer. A generic version of a brand-name drug is permitted to have 10 percent more or less of the active ingredient, though most don't vary that substantially. For many patients this isn't an issue. However some drugs, like medication for seizures and lithium, are called narrow therapeutic index (NTI) drugs; small changes in their concentration in the blood can lead to an ineffective or toxic effect.

Some drugs lose their effectiveness over time. Most have side effects, some psychological and some physical. Some are mild and others more serious. Perhaps most important, most psychiatric drugs have not been tested on children or teenagers.

If you think your child needs to be treated for psychological issues, get a recommendation from your pediatrician for a qualified therapist. The therapist will evaluate the situation, and if they believe it's appropriate, they will refer you to a psychiatrist who specializes in treating children and adolescents. This is critical: children and teens react differently to medication than adults. Your child should also be monitored on a regular basis while they're taking a medication to evaluate its effectiveness and deal with any side effects.

The most commonly used medications to treat anxiety and related disorders in adolescence are antidepressants. These can change the way the brain processes the neurotransmitters, including serotonin, dopamine, and norepinephrine (also known as noradrenaline), that affect mood and emotions.

Selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed to treat anxiety and depression. These antidepressants can temporarily improve mood by blocking the reuptake of the neurotransmitter serotonin. Fluoxetine

(Prozac), sertraline (Zoloft), and paroxetine (Paxil) are SSRIs. These drugs take several weeks to start working, which is a drawback if there's a need to try different medications and find the correct dose. Their short-term and often long-term side effects include nausea, headaches, and sleep problems, which can take days or weeks to subside after stopping these drugs. SSRIs are also being used in clinical trials to treat OCD, social phobias, and eating disorders.

Serotonin-norepinephrine reuptake inhibitors (SNRIs) increase the production of both serotonin and norepinephrine, and prevent their reuptake. SNRIs like venlafaxine ER (Effexor) have similar side effects to SSRIs. There are fewer studies on their long-term impact on teens.

SSRIs and SNRIs both carry the risk of suicidal thoughts and actions. Any adolescent taking these drugs should be closely monitored by their therapist and their doctor.

If SSRIs, SNRIs, or both are ineffective, your teen's doctor may prescribe an older class of drug, a tricyclic antidepressant (TCA). These include amitriptyline (Elavil), imipramine (Tofranil), and clomipramine (Anafranil). The FDA has also approved clomipramine for the treatment of OCD, and sometimes for social anxiety. Serious side effects can occur when taking TCAs, such as constipation, sedation, and cardiac abnormalities. People who take TCAs should have regular EKGs to monitor their cardiac health.

Benzodiazepines, also known as tranquilizers, are not considered a first course of medication treatment for teens because they carry the risk of patients developing tolerance and addiction; when discontinued they can cause powerful withdrawal symptoms. Benzodiazepines include alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), and lorazepam (Ativan). Sometimes these drugs are prescribed with

SSRIs until the SSRI reaches its full effect, which may take as long as eight to twelve weeks. No controlled trials show the benefit of using benzodiazepines to treat anxiety in children.

When considering any psychiatric medication for your child, write down a list of questions and bring them to your child's doctor or mental health professional. I suggest the list include the following:

- Why are you prescribing this medication?
- Does my child have a health condition that contraindicates this medication?
- How long will the medication take to be fully effective?
- How will we know the medication is working?
- What side effects are most common in kids and adolescents?
- Will the side effects subside after a period of time?
- Are any health risks associated with taking this medication? How will those risks be monitored?
- Are any negative side effects commonly associated with discontinuing the medication?
- Will this medication interact negatively with any other medications or supplements my child is taking?
- How long will my child have to take the medication? How will she be weaned off it?
- If the medication isn't working or needs to be discontinued, what are the next steps?

While medication should not be the first line of treatment for ADHD, there are times when medication may be helpful. Options include stimulants, which help focus thoughts and ignore distractions, and non-stimulants, which can improve concentration and impulse control. All these medications have side effects and many of them are addictive. Educate yourself about these medications before you allow them to be prescribed to your child.

About the Author



Erica Komisar, LCSW, is a psychoanalyst and parent guidance expert who is in private practice in New York City. She received her BA from Georgetown University and an MSW from Columbia University and graduated from the Contemporary Freudian Society as a psychoanalyst in 1999, where she teaches adolescent development to psychotherapists in training.

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Notes

Chapter 1

1. Miller, “Mental Health Disorders and Teen Substance Use.”
2. Moretti and Peled, “Adolescent-Parent Attachment.”
3. American Academy of Child and Adolescent Psychiatry, “Attachment Disorders.”
4. Waters et al., “Attachment Security in Infancy and Early Adulthood.”
5. Brumariu and Kerns, “Parent-Child Attachment and Internalizing Symptoms in Childhood and Adolescence.”
6. Stolzenberg et al., *The American Freshman*.
7. Kochhar, “Unemployment Rose Higher in Three Months of COVID-19 Than It Did in Two Years of the Great Recession.”
8. National Center on Addiction and Substance Abuse, “2011 National Teen Survey Finds.”
9. Hall-Lande et al., “Social Isolation, Psychological Health, and Protective Factors in Adolescence.”
10. Holt-Lunstad et al., “Social Relationships and Mortality Risk.”
11. Cacioppo and Hawkley, “Loneliness.”

Chapter 2

1. Steinberg, *Age of Opportunity*.
2. Curtis, "Defining Adolescence."
3. McKie, "Puberty for Girls Is Now Starting Five Years Earlier Than It Did in 1920."
4. Scheer and Moss, "Rises in Early Puberty May Have Environmental Roots."
5. Diamanti-Kandarakis et al., "Endocrine-Disrupting Chemicals."
6. DeNoon, "Earlier Puberty."
7. Kann et al., "Youth Risk Behavior Surveillance."
8. Casey et al., "Adolescent Brain."
9. Forbes and Dahl, "Pubertal Development and Behavior."
10. Laule, "Masturbation and Young Children."
11. Schrobsdorff, "What's Causing Depression and Anxiety in Teens?"

Chapter 3

1. Casey, Getz, and Galván, “Adolescent Brain.”
2. Paus, Keshavan, and Giedd, “Why Do Many Psychiatric Disorders Emerge During Adolescence?”
3. Huttenlocher, *Neural Plasticity*.
4. Urban Child Institute, “Baby’s Brain Begins Now.”
5. Fuhrmann, Knoll, and Blakemore, “Adolescence as a Sensitive Period of Brain Development.”
6. Kolb and Gibb, “Brain Plasticity and Behaviour in the Developing Brain.”
7. Takeuchi et al., “The Impact of Parent-Child Interaction on Brain Structures.”
8. Dekaban and Sadowsky, “Changes in Brain Weights During the Span of Human Life.”
9. Fisher and Eugster, “What Is in Our Environment That Affects Puberty?”
10. Lenroot and Giedd, “Sex Differences in the Adolescent Brain.”
11. Goddings et al., “Understanding the Role of Puberty in Structural and Functional Development of the Adolescent Brain.”
12. Galván, “Need for Sleep in the Adolescent Brain.”
13. Crowley, Acebo, and Carskadon, “Sleep, Circadian Rhythms, and Delayed Phase in Adolescence.”
14. Donahue et al, “Quantitative Assessment of Prefrontal Cortex in Humans Relative to Nonhuman Primates.”
15. Tyng et al., “Influences of Emotion on Learning and Memory.”
16. Blakemore, “Social Brain in Adolescence.”
17. Rizzolatti and Craighero, “Mirror-Neuron System.”
18. Lenzi et al., “Neural Basis of Maternal Communication and Emotional Expression Processing During Infant Preverbal Stage.”
19. Zeanah et al., “Institutional Rearing and Psychiatric Disorders in Romanian Preschool Children.”
20. Padmanabhan et al., “Default Mode Network in Autism.”
21. Schultz, Dayan, and Montague, “Neural Substrate of Prediction and Reward.”
22. Tottenham and Galván, “Stress and the Adolescent Brain.”
23. Wahlstrom et al., “Developmental Changes in Dopamine Neurotransmission in Adolescence.”
24. Suliman et al., “Cumulative Effect of Multiple Trauma on Symptoms of Posttraumatic Stress Disorder, Anxiety, and Depression in Adolescents.”
25. Bello and Hajnal, “Dopamine and Binge Eating Behaviors.”
26. Tymula et al., “Adolescents’ Risk-Taking Behavior Is Driven by Tolerance to Ambiguity.”
27. Allen et al., “Two Faces of Adolescents’ Success with Peers.”
28. Wu et al., “Age-Related Changes in Amygdala-Frontal Connectivity During Emotional Face Processing from Childhood into Young Adulthood.”
29. Hariri et al., “Amygdala Response to Emotional Stimuli.”

- [30.](#) Diamond and Carey, "Developmental Changes in the Representation of Faces."
- [31.](#) Frith, "Social Cognition."
- [32.](#) Ordaz and Luna, "Sex Differences in Physiological Reactivity to Acute Psychosocial Stress in Adolescence."
- [33.](#) Eichenbaum, "Hippocampus."
- [34.](#) Andre et al., "Working Memory Circuit as a Function of Increasing Age in Healthy Adolescence."
- [35.](#) Erickson et al., "Exercise Training Increases Size of Hippocampus and Improves Memory."
- [36.](#) Belujon and Grace, "Regulation of Dopamine System Responsivity and Its Adaptive and Pathological Response to Stress."
- [37.](#) McEwen, Nasca, and Gray, "Stress Effects on Neuronal Structure."
- [38.](#) Rogers et al., "Smaller Amygdala Volume and Reduced Anterior Cingulate Gray Matter Density Associated with History of Post-Traumatic Stress Disorder."

Chapter 4

1. National Center for Biotechnology Information, “Precocious Puberty.”
2. American Psychological Association, “Definitions Related to Sexual Orientation and Gender Diversity in APA Documents.”
3. Adams, “Sex, Gender and Sexuality Explained.”
4. GLAAD, “GLAAD Media Reference Guide—Transgender.”
5. Kosciw et al., *2011 National School Climate Survey*.
6. Planned Parenthood, “New CDC Report on U.S. Teens’ Sexual Behavior Illustrates Adolescents’ Continued Need for Sex Education and Effective Birth Control.”

Chapter 5

- [1.](#) Morris, “Adaptive Affect.”
- [2.](#) Martin et al., “Neurobiology of Anxiety Disorders.”
- [3.](#) American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.
- [4.](#) Casey, Getz, and Galvan, “Adolescent Brain.”
- [5.](#) Fuhrmann, Knoll, and Blakemore, “Adolescence as a Sensitive Period of Brain Development.”
- [6.](#) Eiland and Romeo, “Stress and the Developing Adolescent Brain.”
- [7.](#) Bishop, “Neurocognitive Mechanisms of Anxiety.”
- [8.](#) Kim, Pellman, and Kim, “Stress Effects on the Hippocampus.”
- [9.](#) Tottenham and Galván, “Stress and the Adolescent Brain.”
- [10.](#) Malhotra and Sahoo, “Rebuilding the Brain with Psychotherapy.”
- [11.](#) Van der Kolk et al., “Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder.”
- [12.](#) Zohar, “Epidemiology of Obsessive-Compulsive Disorder in Children and Adolescents.”
- [13.](#) Lisanby et al., “Magnetic Seizure Therapy of Major Depression.”
- [14.](#) Mahapatra and Gupta, “Role of Psilocybin in the Treatment of Depression.”
- [15.](#) Oltedal et al. “Effects of ECT in Treatment of Depression: Study Protocol for a Prospective Neuroradiological Study of Acute and Longitudinal Effects on Brain Structure and Function.”

Chapter 6

1. Şahin et al., “Relationship of Clinical Symptoms with Social Cognition in Children Diagnosed with Attention Deficit Hyperactivity Disorder, Specific Learning Disorder or Autism Spectrum Disorder.”
2. Maier et al. “Altered Cingulate and Amygdala Response Towards Threat and Safe Cues in Attention Deficit Hyperactivity Disorder.”
3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.
4. Kessler and Saline, “My Hypersensitivity Is Real.”
5. Danielson et al., “Prevalence of Parent-Reported ADHD Diagnosis and Associated Treatment Among U.S. Children and Adolescents, 2016.”
6. Xu et al., “Twenty-Year Trends in Diagnosed Attention-Deficit/Hyperactivity Disorder Among US Children and Adolescents, 1997–2016.”
7. Schwarz, “Risky Rise of the Good-Grade Pill.”
8. Mayo Clinic, “Attention-Deficit/Hyperactivity Disorder (ADHD) in Children.”
9. Kajantie et al., “Effects of Sex and Hormonal Status on the Physiological Response to Acute Psychosocial Stress.”
10. Pennington, “Genetics of Learning Disabilities.”
11. Krishnan et al., “Neurobiological Basis of Language Learning Difficulties.”
12. Birth Injury, “Cognitive Developmental Disabilities Due to Birth Injuries.”
13. Koger et al., “Environmental Toxicants and Developmental Disabilities.”
14. Whittaker and Ortiz, “What a Specific Learning Disability Is Not.”
15. National Center for Learning Disabilities, “State of LD.”
16. Cortiella and Horowitz, “State of Learning Disabilities.”
17. Learning Disabilities Association of America, “Oral/Written Language Disorder and Specific Reading Comprehension Deficit.”
18. Learning Disabilities Association of America, “Executive Functioning.”
19. Frye et al., “What Is Nonverbal Learning Disorder?”
20. DeWit et al., “Childhood Stress and Symptoms of Drug Dependence in Adolescence and Early Adulthood.”

Chapter 7

- [1.](#) Stice and Bohon, *Eating Disorders*.
- [2.](#) US Census Bureau, "Annual Estimates of the Resident Population... April 1, 2010, to July 1, 2014."
- [3.](#) South Carolina Department of Mental Health, "Eating Disorder Statistics."
- [4.](#) Eating Disorder Foundation, "About Eating Disorders."
- [5.](#) Searing, "Big Number."
- [6.](#) University of North Carolina–Chapel Hill, "Three out of Four American Women Have Disordered Eating, Survey Suggests."
- [7.](#) Wolfe and Maisto, "Relationship Between Eating Disorders and Substance Use."
- [8.](#) National Institute of Mental Health, "Eating Disorders: About More Than Food."
- [9.](#) LaRosa, "Top 9 Things to Know About the Weight Loss Industry."
- [10.](#) Council on Size and Weight Discrimination, "Statistics on Weight Discrimination."
- [11.](#) Fetters, "What Happens to Your Body When You Go on an Extreme Diet."
- [12.](#) Freizinger et al., "Prevalence of Eating Disorders in Infertile Women."
- [13.](#) Ringer and Crittenden, "Eating Disorders and Attachment."
- [14.](#) Handford, Rapee, and Fardouly, "Influence of Maternal Modeling on Body Image Concerns and Eating Disturbances in Preadolescent Girls."
- [15.](#) National Institute of Mental Health, "Eating Disorders."
- [16.](#) Casarella, "Serious Health Problems Caused by Binge Eating."
- [17.](#) National Eating Disorders Association, "Orthorexia."
- [18.](#) Mayo Clinic, "Is Your Teen at Risk of Developing an Eating Disorder?"

Chapter 8

1. Squeglia, Jacobus, and Tapert, "Influence of Substance Use on Adolescent Brain Development."
2. Centers for Disease Control and Prevention, "Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products."
3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.
4. Robinson and Adinoff, "Classification of Substance Use Disorders."
5. Chapman et al., "Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood."
6. Dube et al., "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use."
7. Weiss et al., "Early Social Isolation, but Not Maternal Separation, Affects Behavioral Sensitization to Amphetamine in Male and Female Adult Rats."
8. Franken et al., "Neurophysiological Evidence for Abnormal Cognitive Processing of Drug Cues in Heroin Dependence."
9. Liebschutz et al., "Relationship Between Sexual and Physical Abuse and Substance Abuse Consequences."
10. Christie et al., "Epidemiologic Evidence for Early Onset of Mental Disorders and Higher Risk of Drug Abuse in Young Adults."
11. Kandel et al., "Psychiatric Comorbidity Among Adolescents with Substance Use Disorders."
12. Chambers et al., "Developmental Neurocircuitry of Motivation in Adolescence."
13. Casey et al., "Adolescent Brain."
14. Somerville et al., "Time of Change."
15. Waelti et al., "Dopamine Responses Comply with Basic Assumptions of Formal Learning Theory."
16. Badiani et al., "Modulation of Morphine Sensitization in the Rat by Contextual Stimuli."
17. Wills et al., "Novelty Seeking, Risk Taking, and Related Constructs as Predictors of Adolescent Substance Use."
18. Savin-Williams, *Adolescence*.
19. Dayan and Balleine, "Reward, Motivation, and Reinforcement Learning."
20. Goto and Grace, "Dopamine Modulation of Hippocampal–Prefrontal Cortical Interaction Drives Memory-Guided Behavior."
21. Gardner and Steinberg, "Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood."
22. Bahr et al., "Parental and Peer Influences on the Risk of Adolescent Drug Use."
23. Kirke, "Chain Reactions in Adolescents' Cigarette, Alcohol and Drug Use."
24. Spear, "Alcohol Consumption in Adolescence."
25. Windle, "Drinking over the Lifespan."
26. National Institute on Drug Abuse, "Drugs and the Brain."

- [27.](#) Lubman et al., "Substance Use and the Adolescent Brain."
- [28.](#) Rutherford et al., "Neurobiology of Adolescent Substance Use Disorders."
- [29.](#) Crews et al., "Adolescent Cortical Development."
- [30.](#) Melgaard et al., "Regional Cerebral Blood Flow in Chronic Alcoholics Measured by Single Photon Emission Computerized Tomography."
- [31.](#) Brown et al., "Developmental Perspective on Alcohol and Youths 16 to 20 Years of Age."
- [32.](#) National Institute of Alcohol Abuse and Alcoholism, "Underage Drinking."
- [33.](#) Monti et al., "Drinking Among Young Adults."
- [34.](#) Silveri and Spear, "Decreased Sensitivity to the Hypnotic Effects of Ethanol Early in Ontogeny."
- [35.](#) Jacobus and Tapert, "Effects of Cannabis on the Adolescent Brain."
- [36.](#) Fuhrmann et al., "Adolescence as a Sensitive Period of Brain Development."
- [37.](#) Friedman et al., "Depression, Negative Self-Image, and Suicidal Attempts as Effects of Substance Use and Substance Dependence."
- [38.](#) National Institute on Drug Abuse, "Parenting to Prevent Childhood Alcohol Use."
- [39.](#) Deas and Thomas, "Overview of Controlled Studies of Adolescent Substance Abuse Treatment."
- [40.](#) Muck et al., "Overview of the Effectiveness of Adolescent Substance Abuse Treatment Models."
- [41.](#) Herzberg, "Quaalude Nostalgia."
- [42.](#) Robison, "Decades of Drug Use."
- [43.](#) National Institute on Drug Abuse, "Opioid Overdose Reversal with Naloxone (Narcan, Evzio)."

Chapter 9

1. Twenge, "Have Smartphones Destroyed a Generation?"
2. Hunt et al., "No More FOMO."
3. Twenge and Campbell, "Associations Between Screen Time and Lower Psychological Well-Being Among Children and Adolescents."
4. Anderson and Jiang, "Teens' Social Media Habits and Experiences."
5. Twenge et al., "Less In-Person Social Interaction with Peers Among US Adolescents in the 21st Century and Links to Loneliness."
6. Jiang, "How Teens and Parents Navigate Screen Time and Device Distractions."
7. Anderson and Jiang, "Teens, Social Media and Technology 2018."
8. World Health Organization, "Addictive Behaviours."
9. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.
10. Floros, "Gambling Disorder in Adolescents."

Chapter 10

1. Bradshaw, Sawyer, and O'Brennan, "Bullying and Peer Victimization at School."
2. Yanez and Seldin, *Student Reports of Bullying*.
3. Rose and Espelage, "Risk and Protective Factors Associated with the Bullying Involvement of Students with Emotional and Behavioral Disorders."
4. Kosciw et al., *2017 National School Climate Survey*.
5. Afifi et al., "Relationships Between Harsh Physical Punishment and Child Maltreatment in Childhood and Intimate Partner Violence in Adulthood."
6. Anderson and Jiang, "Teens and Their Experiences on Social Media."
7. Anderson, "Majority of Teens Have Experienced Some Form of Cyberbullying."
8. George and Odgers, "Seven Fears and the Science of How Mobile Technologies May Be Influencing Adolescents in the Digital Age."
9. Guardchild, "Teenage Sexting Statistics."
10. Gini and Pozzoli, "Bullied Children and Psychosomatic Problems."
11. Gini and Espelage, "Peer Victimization, Cyberbullying, and Suicide Risk in Children and Adolescents."
12. Davis and Nixon, "Youth Voice Project."
13. Hawkins et al., "Naturalistic Observations of Peer Interventions in Bullying."

Chapter 11

- [1.](#) Bloss, "The Second Individuation Process of Adolescence."

Chapter 12

- [1.](#) Freud, “Remembering, Repeating and Working-Through.”

References

Chapter 1

- American Academy of Child and Adolescent Psychiatry. "Attachment Disorders." Accessed August 21, 2020. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Attachment-Disorders-085.aspx.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013.
- Anderson, Monica, and Jingjing Jiang. "Teens, Social Media, and Technology 2018." Pew Research Center, August 14, 2020. <https://www.pewresearch.org/internet/2018/05/31/teens-social-media-technology-2018/>.
- Bowlby, John. *Attachment and Loss*, Vol. 1: *Attachment*. New York: Basic Books, 1969.
- Brumariu, Laura E., and Kathryn A. Kerns. "Parent-Child Attachment and Internalizing Symptoms in Childhood and Adolescence: A Review of Empirical Findings and Future Directions." *Development and Psychopathology* 22, no. 1 (2010): 177–203.
- Bushman, Brad J., Patrick E. Jamieson, Ilana Weitz, and Daniel Romer. "Gun Violence Trends in Movies." *Pediatrics* 132, no. 6 (2013): 1014–18.
- Cacioppo, John T., and Louise C. Hawkley. "Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanisms." *Annals of Behavioral Medicine* 40, no. 2 (2009): 218–27.
- Chen, Ying, and Tyler J. VanderWeele. "Associations of Religious Upbringing with Subsequent Health and Well-Being from Adolescence to Young Adulthood: An Outcome-Wide Analysis." *American Journal of Epidemiology* 187, no. 11 (2018): 2355–64.
- Cigna. "New Cigna Study Reveals Loneliness at Epidemic Levels in America." May 1, 2018. <https://www.multivu.com/players/English/8294451-cigna-us-loneliness-survey/>.
- Curtin, Sally C., and Melonie Heron. "Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017." *NCHS Data Brief*, no. 352. Hyattsville, MD: National Center for Health Statistics, October 2019.
- Dimock, Michael. "Defining Generations: Where Millennials End and Generation z Begins," March 30, 2021. <https://www.pewresearch.org/fact-tank/2019/01/17/where-millennials-end-and-generation-z-begins/>.
- Ferber, Richard. *Solve Your Child's Sleep Problems*. New York: Simon and Schuster, 2006.
- Friedman, Zack. "50 Percent of Millennials Are Moving Back Home with Their Parents After College." *Forbes*, June 7, 2019. <https://www.forbes.com/sites/zackfriedman/2019/06/06/millennials-move-back-home-college/>.
- Gentile, Douglas. "Pathological Video-Game Use Among Youth Ages 8 to 18: A National Study." *Psychological Science* 20, no. 5 (2009): 594–602.

- Hall-Lande, Jennifer A., Maria E. Eisenberg, Sandra L. Christenson, and Dianne Neumark-Sztainer. "Social Isolation, Psychological Health, and Protective Factors in Adolescence." *Adolescence* 42, no. 166 (2007): 265-86.
- Holt-Lunstad, Julianne, Timothy B. Smith, and J. Bradley Layton. "Social Relationships and Mortality Risk: A Meta-Analytic Review." *PLoS Medicine* 7, no. 7 (2010): e1000316.
- Kelley, Tina. "A Fast Track to Toilet Training for Those at the Crawling Stage." *New York Times*, October 9, 2005. <https://www.nytimes.com/2005/10/09/nyregion/a-fast-track-to-toilet-training-for-those-at-the-crawling-stage.html>.
- Kochanska, Grazyna, Sanghag Kim, Robin A. Barry, and Robert A. Philibert. "Children's Geno-types Interact with Maternal Responsive Care in Predicting Children's Competence: Diathesis—Stress or Differential Susceptibility?" *Development and Psychopathology* 23, no. 2 (2011): 605–16.
- Kochhar, Rakesh. "Unemployment Rose Higher in Three Months of COVID-19 Than It Did in Two Years of the Great Recession." Pew Research Center, August 26, 2020. <https://www.pewresearch.org/fact-tank/2020/06/11/unemployment-rose-higher-in-three-months-of-covid-19-than-it-did-in-two-years-of-the-great-recession/>.
- Mahler, Margaret S. "Rapprochement Subphase of the Separation-Individuation Process." *Psychoanalytic Quarterly* 41, no. 4 (1972): 487–506.
- Miller, Caroline. "Mental Health Disorders and Teen Substance Use." Child Mind Insti-tute, January 28, 2020. <https://childmind.org/article/mental-health-disorders-and-substance-use/>.
- Mojtabai, Ramin, Mark Olfson, and Beth Han. "National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults." *Pediatrics* 138, no. 6 (2016): e20161878.
- Moretti, Marlene M., and Maya Peled. "Adolescent-Parent Attachment: Bonds That Support Healthy Development." *Pediatrics and Child Health* 9, no. 8 (2004): 551–55.
- National Alliance on Mental Illness. "Mental Health Facts: Children and Teens." Accessed August 23, 2020. <https://www.nami.org/nami/media/nami-media/infographics/children-mh-facts-nami.pdf>.
- National Center on Addiction and Substance Abuse. "2011 National Teen Survey Finds Teens Regularly Using Social Networking Sites Likelier to Smoke, Drink, Use Drugs." PR Newswire, June 30, 2018. <https://www.prnewswire.com/news-releases/2011-national-teen-survey-finds-teens-regularly-using-social-networking-sites-likelier-to-smoke-drink-use-drugs-128295633.html>.
- National Center on Addiction and Substance Abuse. "Adolescent Substance Use: America's #1 Public Health Problem." June, 2011. <https://files.eric.ed.gov/fulltext/ED521379.pdf>.
- National Institute on Drug Abuse. "Monitoring the Future Survey: High School and Youth Trends DrugFacts." National Institute on Drug Abuse, December 18, 2019. <https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends>.

- National Institute on Drug Abuse. "What Is the Scope of Prescription Drug Misuse?" National Institute on Drug Abuse, April 13, 2020. <https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/what-scope-prescription-drug-misuse>.
- Patchin, Justin W., Torrie Pennington, Julie Otto, and Sameer Hinduja. "2016 Cyberbullying Data." Cyberbullying Research Center, February 3, 2020. <https://cyberbullying.org/2016-cyberbullying-data>.
- Pratt, Laura A., Debra J. Brody, and Qiuping Gu. "Antidepressant Use in Persons Aged 12 and Over: United States, 2005–2008." Centers for Disease Control and Prevention. Last modified November 6, 2015. <https://www.cdc.gov/nchs/products/databriefs/db76.htm>.
- Steinberg, Laurence. *Age of Opportunity: Lessons from the New Science of Adolescence*. New York: Houghton Mifflin Harcourt, 2014.
- Stolzenberg, Ellen B., Melissa C. Aragon, Edgar Romo, Victoria Couch, Destiny McLennan, M. Kevin Eagan, and Nathaniel Kang. *The American Freshman: National Norms Fall 2019*. Los Angeles: Higher Education Research Institute, UCLA, 2020.
- Uhls, Yalda T., and Patricia M. Greenfield. "The Value of Fame: Preadolescent Perceptions of Popular Media and Their Relationship to Future Aspirations." *Developmental Psychology* 48, no. 2 (2012): 315-26.
- Waters, Everett, Susan Merrick, Dominique Treboux, Judith Crowell, and Leah Albersheim. "Attachment Security in Infancy and Early Adulthood: A Twenty-Year Longitudinal Study." *Child Development* 71, no. 3 (2000): 684–89.
- World Health Organization. *International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision)*. Geneva: World Health Organization, 2018.
- Zuckerbrot, Rachel A., Amy Cheung, Peter S. Jensen, Ruth E. K. Stein, Danielle Laraque, and GLAD-PC STEERING GROUP. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management." *Pediatrics* 141, no. 3 (2018): 1-21.

Chapter 2

- Casey, Betty Jo, Sarah Getz, and Adriana Galvan. "The Adolescent Brain." *Developmental Review* 28, no. 1 (2008): 62–77.
- Center on the Developing Child. *The Science of Early Childhood Development* (InBrief). 2017. www.developingchild.harvard.edu.
- Curtis, Alexa C. "Defining Adolescence." *Journal of Adolescent and Family Health* 7, no. 2 (2015).
- DeNoon, Daniel J. "Earlier Puberty: Age 9 or 10 for Average U.S. Boy." WebMD, October 19, 2012. <https://www.webmd.com/children/news/20121020/earlier-puberty-age-9-10-average-us-boy>.
- Diamanti-Kandarakis, Evanthia, Jean-Pierre Bourguignon, Linda C. Giudice, Russ Hauser, Gail S. Prins, Ana M. Soto, R. Thomas Zoeller, and Andrea C. Gore. "Endocrine-Disrupting Chemicals: An Endocrine Society Scientific Statement." *Endocrine Reviews* 30, no. 4 (2009): 293–342.
- Forbes, Erika E., and Ronald E. Dahl. "Pubertal Development and Behavior: Hormonal Activation of Social and Motivational Tendencies." *Brain and Cognition* 72, no. 1 (2010): 66–72.
- Johnston, Lloyd D., Patrick M. O'Malley, Jerald G. Bachman, and John E. Schulenberg. *Monitoring the Future National Survey Results on Drug Use, 1975–2010. Volume I: Secondary School Students*. Ann Arbor, Michigan: University of Michigan Institute for Social Research, (2011).
- Kann, L., T. McManus, W. A. Harris, et al. "Youth Risk Behavior Surveillance—United States, 2017." *Morbidity and Mortality Weekly Report: Surveillance Summaries* 67, no. SS-8 (June 15, 2018): 1–114.
- Laule, Sara. "Masturbation and Young Children." CS Mott Children's Hospital, Michigan Medicine, July 2017. <https://www.mottchildren.org/posts/your-child/masturbation-and-young-children>.
- Mahler, Margaret S. "Symbiosis and Individuation: The Psychological Birth of the Human Infant." *Psychoanalytic Study of the Child* 29, no. 1 (1974): 89–106.
- McKie, Robin. "Puberty for Girls Is Now Starting Five Years Earlier Than It Did in 1920." *Business Insider*, October 23, 2012. <https://www.businessinsider.com/female-puberty-starting-earlier-2012-10>.
- Scheer, Roddy, and Doug Moss. "Rises in Early Puberty May Have Environmental Roots." *Scientific American*, October 19, 2013. <https://www.scientificamerican.com/article/rises-in-early-puberty-may-have-environmental-roots/>.
- Schrobsdorff, Susanna. "What's Causing Depression and Anxiety in Teens?" *Time*, October 27, 2016. <https://time.com/4547322/american-teens-anxious-depressed-overwhelmed/>.
- Steinberg, Laurence. *Age of Opportunity: Lessons from the New Science of Adolescence*. New York: Houghton Mifflin Harcourt, 2014.

Chapter 3

- Allen, Joseph P., Maryfrances R. Porter, F. Christy McFarland, Penny Marsh, and Kathleen Boykin McElhaney. "The Two Faces of Adolescents' Success with Peers: Adolescent Popularity, Social Adaptation, and Deviant Behavior." *Child Development* 76, no. 3 (2005): 747–60.
- Andre, Julia, Marco Picchioni, Ruibin Zhang, and Timothea Touloupoulou. "Working Memory Circuit as a Function of Increasing Age in Healthy Adolescence: A Systematic Review and Meta-Analyses." *NeuroImage: Clinical* 12 (2016): 940–48.
- Basch, Charles E., Corey H. Basch, Kelly V. Ruggles, and Sonali Rajan. "Peer Reviewed: Prevalence of Sleep Duration on an Average School Night Among 4 Nationally Representative Successive Samples of American High School Students, 2007–2013." *Preventing Chronic Disease* 11, E216 (2014): 1-5.
- Bello, Nicholas T., and Andras Hajnal. "Dopamine and Binge Eating Behaviors." *Pharmacology Biochemistry and Behavior* 97, no. 1 (2010): 25–33.
- Belujon, Pauline, and Anthony A. Grace. "Regulation of Dopamine System Responsivity and Its Adaptive and Pathological Response to Stress." *Proceedings of the Royal Society B: Biological Sciences* 282, no. 1805 (2015).
- Blakemore, Sarah-Jayne. "The Social Brain in Adolescence." *Nature Reviews Neuroscience* 9, no. 4 (2008): 267–77.
- Casey, B. J., Sarah Getz, and Adriana Galvan. "The Adolescent Brain." *Developmental Review* 28, no. 1 (2008): 62–77.
- Centers for Disease Control and Prevention. "Smoking and Youth," 2018. https://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/pdfs/fs_smoking_youth_508.pdf.
- Chein, Jason, Dustin Albert, Lia O'Brien, Kaitlyn Uckert, and Laurence Steinberg. "Peers Increase Adolescent Risk Taking by Enhancing Activity in the Brain's Reward Circuitry." *Developmental Science* 14, no. 2 (2011): F1–F10.
- Crowley, Stephanie J., Christine Acebo, and Mary A. Carskadon. "Sleep, Circadian Rhythms, and Delayed Phase in Adolescence." *Sleep Medicine* 8, no. 6 (2007): 602–12.
- Davidow, Juliet Y., Karin Foerde, Adriana Galván, and Daphna Shohamy. "An Upside to Reward Sensitivity: The Hippocampus Supports Enhanced Reinforcement Learning in Adolescence." *Neuron* 92, no. 1 (2016): 93–99.
- Dekaban, Anatole S., and Doris Sadowsky. "Changes in Brain Weights During the Span of Human Life: Relation of Brain Weights to Body Heights and Body Weights." *Annals of Neurology: Official Journal of the American Neurological Association and the Child Neurology Society* 4, no. 4 (1978): 345–56.
- Diamond, Rhea, and Susan Carey. "Developmental Changes in the Representation of Faces." *Journal of Experimental Child Psychology* 23, no. 1 (1977): 1–22.
- Donahue, Chad J., Matthew F. Glasser, Todd M. Preuss, James K. Rilling, and David C. Van Essen. "Quantitative Assessment of Prefrontal Cortex in Humans Relative to

- Nonhuman Primates.” *Proceedings of the National Academy of Sciences* 115, no. 22 (2018): E5183–E5192.
- Eichenbaum, Howard. “Hippocampus: Cognitive Processes and Neural Representations That Underlie Declarative Memory.” *Neuron* 44, no. 1 (2004): 109–20.
- Erickson, Kirk I., Michelle W. Voss, Ruchika Shaurya Prakash, Chandramallika Basak, Amanda Szabo, Laura Chaddock, Jennifer S. Kim, et al. “Exercise Training Increases Size of Hippocampus and Improves Memory.” *Proceedings of the National Academy of Sciences* 108, no. 7 (2011): 3017–22.
- Ernst, Monique, Eric E. Nelson, Sandra Jazbec, Erin B. McClure, Christopher S. Monk, Ellen Leibenluft, James Blair, and Daniel S. Pine. “Amygdala and Nucleus Accumbens in Responses to Receipt and Omission of Gains in Adults and Adolescents.” *Neuroimage* 25, no. 4 (2005): 1279–91.
- Fisher, Marisa M., and Erica A. Eugster. “What Is in Our Environment That Affects Puberty?” *Reproductive Toxicology* 44 (2014): 7–14.
- Freud, Sigmund. “Three Essays on the Theory of Sexuality (1905).” In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, volume VII (1901–1905): *A Case of Hysteria, Three Essays on Sexuality, and Other Works*, 123–246. London: Hogarth Press, 1953.
- Frith, Chris D. “Social Cognition.” *Philosophical Transactions of the Royal Society B: Biological Sciences* 363, no. 1499 (2008): 2033–39.
- Fuhrmann, Delia, Lisa J. Knoll, and Sarah-Jayne Blakemore. “Adolescence as a Sensitive Period of Brain Development.” *Trends in Cognitive Sciences* 19, no. 10 (2015): 558–66.
- Galván, Adriana. “The Need for Sleep in the Adolescent Brain.” *Trends in Cognitive Sciences* 24, no. 1 (2020): 79–89.
- Goddings, Anne-Lise, Adriene Beltz, Jiska S. Peper, Eveline A. Crone, and Barbara R. Braams. “Understanding the Role of Puberty in Structural and Functional Development of the Adolescent Brain.” *Journal of Research on Adolescence* 29, no. 1 (2019): 32–53.
- Hariri, Ahmad R., Alessandro Tessitore, Venkata S. Mattay, Francesco Fera, and Daniel R. Weinberger. “The Amygdala Response to Emotional Stimuli: A Comparison of Faces and Scenes.” *Neuroimage* 17, no. 1 (2002): 317–23.
- Heron, Melonie. “Deaths: Leading Causes for 2017.” National Center for Health Statistics. *National Vital Statistics Reports* 68, no. 6 (2019): 1-77.
- Huttenlocher, Peter R. *Neural Plasticity*. Cambridge, MA: Harvard University Press, 2009.
- Kolb, Bryan, and Robbin Gibb. “Brain Plasticity and Behaviour in the Developing Brain.” *Journal of the Canadian Academy of Child and Adolescent Psychiatry* 20, no. 4 (2011): 265-76.
- Lenroot, Rhoshel K., and Jay N. Giedd. “Sex Differences in the Adolescent Brain.” *Brain and Cognition* 72, no. 1 (2010): 46–55.

- Lenzi, Delia, Claudia Trentini, Patrizia Pantano, Eugenio Macaluso, Marco Iacoboni, G. L. Lenzi, and Massimo Ammaniti. "Neural Basis of Maternal Communication and Emotional Expression Processing During Infant Preverbal Stage." *Cerebral Cortex* 19, no. 5 (2009): 1124–33.
- McEwen, Bruce S., Carla Nasca, and Jason D. Gray. "Stress Effects on Neuronal Structure: Hippocampus, Amygdala, and Prefrontal Cortex." *Neuropsychopharmacology* 41, no. 1 (2016): 3–23.
- Ordaz, Sarah, and Beatriz Luna. "Sex Differences in Physiological Reactivity to Acute Psychosocial Stress in Adolescence." *Psychoneuroendocrinology* 37, no. 8 (2012): 1135–57.
- Padmanabhan, Aarthi, Charles J. Lynch, Marie Schaer, and Vinod Menon. "The Default Mode Network in Autism." *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging* 2, no. 6 (2017): 476–86.
- Paus, Tomáš, Matcheri Keshavan, and Jay N. Giedd. "Why Do Many Psychiatric Disorders Emerge During Adolescence?" *Nature Reviews Neuroscience* 9, no. 12 (2008): 947–57.
- Rizzolatti, Giacomo, and Laila Craighero. "The Mirror-Neuron System." *Annual Review of Neuroscience* 27 (2004): 169–92.
- Rogers, Mark A., Hidenori Yamasue, Osamu Abe, Haruyasu Yamada, Toshiyuki Ohtani, Akira Iwanami, Shigeki Aoki, Nobumasa Kato, and Kiyoto Kasai. "Smaller Amygdala Volume and Reduced Anterior Cingulate Gray Matter Density Associated with History of Post-Traumatic Stress Disorder." *Psychiatry Research: Neuroimaging* 174, no. 3 (2009): 210–16.
- Schultz, Wolfram, Peter Dayan, and P. Read Montague. "A Neural Substrate of Prediction and Reward." *Science* 275, no. 5306 (1997): 1593–99.
- Suliman, Sharain, Siyabulela G. Mkabile, Dylan S. Fincham, Rashid Ahmed, Dan J. Stein, and Soraya Seedat. "Cumulative Effect of Multiple Trauma on Symptoms of Posttraumatic Stress Disorder, Anxiety, and Depression in Adolescents." *Comprehensive Psychiatry* 50, no. 2 (2009): 121–27.
- Takeuchi, Hikaru, Yasuyuki Taki, Hiroshi Hashizume, Kohei Asano, Michiko Asano, Yuko Sassa, Susumu Yokota, Yuka Kotozaki, Rui Nouchi, and Ryuta Kawashima. "The Impact of Parent-Child Interaction on Brain Structures: Cross-Sectional and Longitudinal Analyses." *Journal of Neuroscience* 35, no. 5 (2015): 2233–45.
- Tottenham, Nim, and Adriana Galván. "Stress and the Adolescent Brain: Amygdala–Prefrontal Cortex Circuitry and Ventral Striatum as Developmental Targets." *Neuroscience and Biobehavioral Reviews* 70 (2016): 217–27.
- Tymula, Agnieszka, Lior A. Rosenberg Belmaker, Amy K. Roy, Lital Ruderman, Kirk Manson, Paul W. Glimcher, and Ifat Levy. "Adolescents' Risk-Taking Behavior Is Driven by Tolerance to Ambiguity." *Proceedings of the National Academy of Sciences* 109, no. 42 (2012): 17135–40.
- Tyng, Chai M., Hafeez U. Amin, Mohamad N. M. Saad, and Aamir S. Malik. "The Influences of Emotion on Learning and Memory." *Frontiers in Psychology* 8 (2017): 1454.

- Urban Child Institute. "Baby's Brain Begins Now: Conception to Age 3." Urban Child Institute, 2020. <http://www.urbanchildinstitute.org/why-0-3/baby-and-brain>.
- Wahlstrom, Dustin, Paul Collins, Tonya White, and Monica Luciana. "Developmental Changes in Dopamine Neurotransmission in Adolescence: Behavioral Implications and Issues in Assessment." *Brain and Cognition* 72, no. 1 (2010): 146–59.
- Williams, Kipling D., Christopher K. T. Cheung, and Wilma Choi. "Cyberostracism: Effects of Being Ignored over the Internet." *Journal of Personality and Social Psychology* 79, no. 5 (2000): 748-62.
- Wu, Minjie, Autumn Kujawa, Lisa H. Lu, Daniel A. Fitzgerald, Heide Klumpp, Kate D. Fitzgerald, Christopher S. Monk, and K. Luan Phan. "Age-Related Changes in Amygdala–Frontal Connectivity During Emotional Face Processing from Childhood into Young Adulthood." *Human Brain Mapping* 37, no. 5 (2016): 1684–95.
- Zeanah, Charles H., Helen L. Egger, Anna T. Smyke, Charles A. Nelson, Nathan A. Fox, Peter J. Marshall, and Donald Guthrie. "Institutional Rearing and Psychiatric Disorders in Romanian Preschool Children." *American Journal of Psychiatry* 166, no. 7 (2009): 777–85.

Chapter 4

- Abma, Joyce C., and Gladys M. Martinez. "Sexual Activity and Contraceptive Use Among Teenagers in the United States, 2011–2015." *National Health Statistics Reports* 104 (2017): 1–23.
- Adams, Cydney. "The Difference Between Sexual Orientation and Gender Identity." CBS News, March 28, 2017. <https://www.cbsnews.com/news/the-difference-between-sexual-orientation-and-gender-identity/>.
- Adams, Leah. "Sex, Gender and Sexuality Explained." HIV Services–HIV Treatment, Prevention and Care. Western Australian AIDS Council. Accessed August 31, 2020. <https://waaids.com/item/736-sexuality.html>.
- American Psychological Association. "Definitions Related to Sexual Orientation and Gender Diversity in APA Documents." Accessed August 31, 2020. <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>.
- Centers for Disease Control and Prevention. "Over Half of U.S. Teens Have Had Sexual Intercourse by Age 18, New Report Shows." June 22, 2017. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2017/201706_NSFG.htm.
- Centers for Disease Control and Prevention. "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9–12—United States and Selected Sites, 2015." CDC, 2015. <https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6509.pdf>.
- Freud, Sigmund. "Three Essays on the Theory of Sexuality (1905)." In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Volume VII (1901–1905): *A Case of Hysteria, Three Essays on Sexuality, and Other Works*. London: Hogarth Press, 1953.
- Gay and Lesbian Alliance Against Defamation. "GLAAD Media Reference Guide—Transgender." GLAAD, December 7, 2019. <https://www.glaad.org/reference/transgender>.
- Kann, Laura, Tim McManus, William A. Harris, Shari L. Shanklin, Katherine H. Flint, Joseph Hawkins, Barbara Queen, et al. "Youth Risk Behavior Surveillance—United States, 2015." *Morbidity and Mortality Weekly Report: Surveillance Summaries* 65, no. 6 (2016): 1–174.
- Kann, Laura, Tim McManus, William A. Harris, Shari L. Shanklin, Katherine H. Flint, Barbara Queen, Richard Lowry, et al. "Youth Risk Behavior Surveillance—United States, 2017." *Morbidity and Mortality Weekly Report: Surveillance Summaries* 67, no. 8 (2018): 1–174.
- Kosciw, Joseph G., Emily A. Greytak, Mark J. Bartkiewicz, Madelyn J. Boesen, and Neal A. Palmer. *The 2011 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*. New York: Gay, Lesbian and Straight Education Network (GLSEN), 2012.
- National Center for Biotechnology Information. "Precocious Puberty." 2011. <https://medlineplus.gov/ency/article/001168.htm>

Planned Parenthood. “New CDC Report on U.S. Teens’ Sexual Behavior Illustrates Adolescents’ Continued Need for Sex Education and Effective Birth Control.” June 22, 2017. <https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-new-cdc-report-on-u-s-teens-sexual-behavior-illustrates-adolescents-continued-need-for-sex-education-and-effective-birth-control>.

Chapter 5

- American Academy of Child and Adolescent Psychiatry. "Your Adolescent–Anxiety and Avoidant Disorders." Accessed September 17, 2020. https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Your_Adolescent_Anxiety_and_Avoidant_Disorders.aspx.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013.
- Bishop, Sonia J. "Neurocognitive Mechanisms of Anxiety: An Integrative Account." *Trends in Cognitive Sciences* 11, no. 7 (2007): 307–16.
- Casey, Betty Jo, Sarah Getz, and Adriana Galvan. "The Adolescent Brain." *Developmental Review* 28, no. 1 (2008): 62–77.
- Centers for Disease Control and Prevention. "Autism and Developmental Disabilities Monitoring (ADMM) Network." CDC, March 26, 2020. <https://www.cdc.gov/ncbddd/autism/addm.html>.
- Child Mind Institute. "Understanding Anxiety in Children and Teens: 2018 Children's Mental Health Report." Child Mind Institute, 2018. https://childmind.org/downloads/CMI_2018C-MHR.pdf.
- Eiland, Lisa, and Russell D. Romeo. "Stress and the Developing Adolescent Brain." *Neuroscience* 249 (2013): 162–71.
- Forsell, Lena M., and Jan A. Åström. "Meanings of Hugging: From Greeting Behavior to Touching Implications." *Comprehensive Psychology* 1 (2012): 2–17.
- Fuhrmann, Delia, Lisa J. Knoll, and Sarah-Jayne Blakemore. "Adolescence as a Sensitive Period of Brain Development." *Trends in Cognitive Sciences* 19, no. 10 (2015): 558–66.
- Kim, Eun Joo, Blake Pellman, and Jeansok J. Kim. "Stress Effects on the Hippocampus: A Critical Review." *Learning and Memory* 22, no. 9 (2015): 411–16.
- Lisanby, Sarah H., Thomas E. Schlaepfer, Hans-Ulrich Fisch, and Harold A. Sackeim. "Magnetic Seizure Therapy of Major Depression." *Archives of General Psychiatry* 58, no. 3 (2001): 303–5.
- Mahapatra, Ananya, and Rishi Gupta. "Role of Psilocybin in the Treatment of Depression." *Therapeutic Advances in Psychopharmacology* 7, no. 1 (2017): 54–56.
- Malhotra, Savita, and Swapnajeet Sahoo. "Rebuilding the Brain with Psychotherapy." *Indian Journal of Psychiatry* 59, no. 4 (2017): 411.
- Martin, Elizabeth I., Kerry J. Ressler, Elisabeth Binder, and Charles B. Nemeroff. "The Neurobiology of Anxiety Disorders: Brain Imaging, Genetics, and Psychoneuroendocrinology." *Psychiatric Clinics* 32, no. 3 (2009): 549–75.
- Merikangas, Kathleen Ries, Jian-ping He, Marcy Burstein, Sonja A. Swanson, Shelli Avenevoli, Lihong Cui, Corina Benjet, Katholiki Georgiades, and Joel Swendsen. "Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A)." *Journal of the American Academy of Child and Adolescent Psychiatry* 49, no. 10 (2010): 980–89.

- Mojtabai, Ramin, Mark Olfson, and Beth Han. "National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults." *Pediatrics* 138, no. 6 (2016): e20161878.
- Morris, David W. "Adaptive Affect: The Nature of Anxiety and Depression." *Neuropsychiatric Disease and Treatment* 15 (2019): 3323-26.
- National Center for Health Statistics. "Chapter 28: Mental Health and Mental Disorders." *Healthy People 2020 Midcourse Review*. Hyattsville, MD, 2016.
- Oltegal, Leif, Ute Kessler, Lars Ersland, Renate Gruner, Ole A. Andreassen, Jan Haavik, Per Ivar Hoff, et al. "Effects of ECT in Treatment of Depression: Study Protocol for a Prospective Neuroradiological Study of Acute and Longitudinal Effects on Brain Structure and Function." *BMC Psychiatry* 15, no. 1 (2015): 1-10.
- Tottenham, Nim, and Adriana Galván. "Stress and the Adolescent Brain: Amygdala-Prefrontal Cortex Circuitry and Ventral Striatum as Developmental Targets." *Neuroscience and Biobehavioral Reviews* 70 (2016): 217-27.
- Twenge, Jean M. "Time Period and Birth Cohort Differences in Depressive Symptoms in the US, 1982-2013." *Social Indicators Research* 121, no. 2 (2015): 437-54.
- Van der Kolk, Bessel A., Joseph Spinazzola, Margaret E. Blaustein, James W. Hopper, Elizabeth K. Hopper, Deborah L. Korn, and William B. Simpson. "A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance." *Journal of Clinical Psychiatry* 68, no. 1 (2007): 37.
- Zohar, Ada H. "The Epidemiology of Obsessive-Compulsive Disorder in Children and Adolescents." *Child and Adolescent Psychiatric Clinics* 8, no. 3 (1999): 445-60.

Chapter 6

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013.
- Birth Injury. "Cognitive Developmental Disabilities Due to Birth Injuries." Birth Injury Guide, January 6, 2020. <https://www.birthinjuryguide.org/birth-injury/types/cognitive-developmental-disabilities/>.
- Cortiella, Candace, and Sheldon H. Horowitz. "The State of Learning Disabilities: Facts, Trends and Emerging Issues." *New York: National Center for Learning Disabilities* 25 (2014): 2–45.
- Danielson, Melissa L., Rebecca H. Bitsko, Reem M. Ghandour, Joseph R. Holbrook, Michael D. Kogan, and Stephen J. Blumberg. "Prevalence of Parent-Reported ADHD Diagnosis and Associated Treatment Among US Children and Adolescents, 2016." *Journal of Clinical Child and Adolescent Psychology* 47, no. 2 (2018): 199–212.
- DeWit, David J., Kathryn MacDonald, and David R. Offord. "Childhood Stress and Symptoms of Drug Dependence in Adolescence and Early Adulthood." *American Journal of Orthopsychiatry* 69, no. 1 (1999): 61–72.
- Frye, Devon, Linda Karanzalis, and ADDitude's ADHD Medical Review Panel. "What Is Nonverbal Learning Disorder?" ADDitude, March 2, 2020. <https://www.additudemag.com/what-is-nonverbal-learning-disorder-symptoms-and-diagnosis/>.
- Herman, James P., Michelle M. Ostrander, Nancy K. Mueller, and Helmer Figueiredo. "Limbic System Mechanisms of Stress Regulation: Hypothalamo-pituitary-adrenocortical Axis." *Progress in Neuro-Psychopharmacology and Biological Psychiatry* 29, no. 8 (2005): 1201–13.
- Kajantie, Eero, and David I. W. Phillips. "The Effects of Sex and Hormonal Status on the Physiological Response to Acute Psychosocial Stress." *Psychoneuroendocrinology* 31, no. 2 (2006): 151–78.
- Kessler, Zoë, and Sharon Saline. "My Hypersensitivity Is Real: Why Highly Sensitive People Have ADHD." December 19, 2019. <https://www.additudemag.com/hypersensitivity-disorder-with-adhd/>.
- Koger, Susan M., Ted Schettler, and Bernard Weiss. "Environmental Toxicants and Developmental Disabilities: A Challenge for Psychologists." *American Psychologist* 60, no. 3 (2005): 243–55.
- Krishnan, Saloni, Kate E. Watkins, and Dorothy V. M. Bishop. "Neurobiological Basis of Language Learning Difficulties." *Trends in Cognitive Sciences* 20, no. 9 (2016): 701–14.
- Learning Disabilities Association of America. "Executive Functioning." LDAA, September 2, 2013. <https://ldaamerica.org/disabilities/executive-functioning/>.
- Learning Disabilities Association of America. "Oral/Written Language Disorder and Specific Reading Comprehension Deficit." LDAA, July 8, 2020. <https://ldaamerica.org/disabilities/language-processing-disorder/>.

- Learning Disabilities Association of America. "Types of Learning Disabilities." LDAA. Accessed September 28, 2020. <https://ldaamerica.org/types-of-learning-disabilities/>.
- Maier, S. J., A. Szalkowski, S. Kamphausen, B. Feige, E. Perlov, R. Kalisch, G. A. Jacob, A. Philipsen, O. Tüscher, and L. Tebartz van Elst. "Altered Cingulate and Amygdala Response Towards Threat and Safe Cues in Attention Deficit Hyperactivity Disorder." *Psychological Medicine* 44, no. 1 (2014): 85-98.
- Mayo Clinic. "Attention-Deficit/Hyperactivity Disorder (ADHD) in Children." Mayo Clinic, Mayo Foundation for Medical Education and Research, June 25, 2019. <https://www.mayoclinic.org/diseases-conditions/adhd/diagnosis-treatment/drc-20350895>.
- National Center for Learning Disabilities. "The State of LD: Understanding the 1 in 5." NCLD, October 23, 2019. <https://nclld.org/news/newsroom/the-state-of-ld-understanding-the-1-in-5>.
- National Institute of Mental Health. "Social Anxiety Disorder: More Than Just Shyness." US Department of Health and Human Services. Accessed October 4, 2020. <https://www.nimh.nih.gov/health/publications/social-anxiety-disorder-more-than-just-shyness/index.shtml>.
- Pennington, Bruce F. "Genetics of Learning Disabilities." *Journal of Child Neurology* 10, no.1_suppl (1995): S69–S77.
- Şahin, Berkan, Koray Karabekiroğlu, Abdullah Bozkurt, Miraç Barış Usta, Muazzez Aydın, and Cansu Çobanoğlu. "The Relationship of Clinical Symptoms with Social Cognition in Children Diagnosed with Attention Deficit Hyperactivity Disorder, Specific Learning Disorder or Autism Spectrum Disorder." *Psychiatry Investigation* 15, no. 12 (2018): 1144-53.
- Schwarz, Alan. "Risky Rise of the Good-Grade Pill." *New York Times*, June 9, 2012. <https://www.nytimes.com/2012/06/10/education/seeking-academic-edge-teenagers-abuse-stimulants.html>.
- Whittaker, Meghan, and Samuel O. Ortiz. "What a Specific Learning Disability Is Not: Examining Exclusionary Factors." National Center for Disabilities, December 12, 2019. </uploads/2019/11/What-a-Specific-Learning-Disability-Is-Not-Examining-Exclusionary-Factors.12192019.pdf>.
- Xu, Guifeng, Lane Strathearn, Buyun Liu, Binrang Yang, and Wei Bao. "Twenty-Year Trends in Diagnosed Attention-Deficit/Hyperactivity Disorder Among US Children and Adolescents, 1997–2016." *JAMA Network Open* 1, no. 4 (2018): e181471.

Chapter 7

- Casarella, Jennifer. "Serious Health Problems Caused by Binge Eating." WebMD, September 28, 2020. <https://www.webmd.com/mental-health/eating-disorders/binge-eating-disorder/health-problems-binge-eating>.
- Council on Size and Weight Discrimination. "Statistics on Weight Discrimination: A Waste of Talent." Council on Size and Weight Discrimination, 2011. <http://cswd.org/statistics>
- Eating Disorder Foundation. "About Eating Disorders." Eating Disorder Foundation.org. Accessed October 13, 2020. <https://eatingdisorderfoundation.org/learn-more/about-eating-disorders/health-consequences/>.
- Fetters, K. Aleisha. "What Happens to Your Body When You Go on an Extreme Diet." *U.S. News and World Report*, June 19, 2015. <https://health.usnews.com/health-news/health-wellness/articles/2015/06/19/what-happens-to-your-body-when-you-go-on-an-extreme-diet>.
- Freizinger, Melissa, Debra L. Franko, Marie Dacey, Barbara Okun, and Alice D. Domar. "The Prevalence of Eating Disorders in Infertile Women." *Fertility and Sterility* 93, no. 1 (2010): 72–78.
- Handford, Charlotte M., Ronald M. Rapee, and Jasmine Fardouly. "The Influence of Maternal Modeling on Body Image Concerns and Eating Disturbances in Preadolescent Girls." *Behaviour Research and Therapy* 100 (2018): 17–23.
- Hoek, Hans Wijbrand, and Daphne Van Hoeken. "Review of the Prevalence and Incidence of Eating Disorders." *International Journal of Eating Disorders* 34, no. 4 (2003): 383–96.
- LaRosa, John. "Top 9 Things to Know About the Weight Loss Industry." Market Research Blog. Accessed November 5, 2020. <https://blog.marketresearch.com/u.s.-weight-loss-industry-grows-to-72-billion>.
- Le Grange, Daniel, and James Lock. "Maudsley Parents." Maudsley Parents Family-Based Treatment for Eating Disorders, Anorexia Nervosa, and Bulimia Nervosa. Accessed October 15, 2020. <http://maudsleyparents.org/whatismaudsley.html>.
- Mayo Clinic. "Is Your Teen at Risk of Developing an Eating Disorder?" Mayo Foundation for Medical Education and Research, June 5, 2020. <https://www.mayoclinic.org/healthy-lifestyle/tween-and-teen-health/in-depth/teen-eating-disorders/art-20044635>.
- Merikangas, Kathleen Ries, Jian-ping He, Marcy Burstein, Sonja A. Swanson, Shelli Avenevoli, Lihong Cui, Corina Benjet, Katholiki Georgiades, and Joel Swendsen. "Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A)." *Journal of the American Academy of Child and Adolescent Psychiatry* 49, no. 10 (2010): 980–89.
- National Eating Disorders Association. "Eating Disorders in Men and Boys," NEDA, February 26, 2018. <https://www.nationaleatingdisorders.org/learn/general->

[information/research-on-males.](#)

National Eating Disorders Association. "Orthorexia." NEDA, December 13, 2019. <https://www.nationaleatingdisorders.org/learn/by-eating-disorder/other/orthorexia>.

National Institute of Mental Health. "Eating Disorders." US Department of Health and Human Services, February 2016. <https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml>.

National Institute of Mental Health. "Eating Disorders: About More Than Food." US Department of Health and Human Services, 2018. <https://www.nimh.nih.gov/health/publications/eating-disorders-listing>.

Ringer, Francoise, and Patricia McKinsey Crittenden. "Eating Disorders and Attachment: The Effects of Hidden Family Processes on Eating Disorders." *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association* 15, no. 2 (2007): 119–30.

Searing, Linda. "The Big Number: 45 Million Americans Go on a Diet Each Year." *Washington Post*, January 1, 2018. https://www.washingtonpost.com/national/health-science/the-big-number-45-million-americans-go-on-a-diet-each-year/2017/12/29/04089aec-ebdd-11e7-b698-91d4e35920a3_story.html.

South Carolina Department of Mental Health. "Eating Disorder Statistics." Accessed October 10, 2020. <https://www.state.sc.us/dmh/anorexia/statistics.htm>.

Stice, Eric, and Cara Bohon. "Eating Disorders." In Theodore Beauchaine and Stephen Linshaw, eds., *Child and Adolescent Psychopathology*, 2nd ed. New York: Wiley, 2012, 643–69.

University of North Carolina at Chapel Hill. "Three out of Four American Women Have Disordered Eating, Survey Suggests." ScienceDaily. Accessed October 11, 2020. www.sciencedaily.com/releases/2008/04/080422202514.htm.

US Census Bureau, Population Division. "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2018." 2018. <https://www2.census.gov/programs-surveys/popest/tables/2010-2018/national/asrh/PEPAGESEX.pdf>

Wolfe, Wendy L., and Stephen A. Maisto. "The Relationship Between Eating Disorders and Substance Use: Moving Beyond Co-Prevalence Research." *Clinical Psychology Review* 20, no. 5 (2000): 617–31.

Chapter 8

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013.
- Andersen, Susan L., and Martin H. Teicher. "Desperately Driven and No Brakes: Developmental Stress Exposure and Subsequent Risk for Substance Abuse." *Neuroscience and Biobehavioral Reviews* 33, no. 4 (2009): 516–24.
- Badiani, Aldo, Mitchell M. Oates, and Terry E. Robinson. "Modulation of Morphine Sensitization in the Rat by Contextual Stimuli." *Psychopharmacology* 151, nos. 2–3 (2000): 273–82.
- Bahr, Stephen J., John P. Hoffmann, and Xiaoyan Yang. "Parental and Peer Influences on the Risk of Adolescent Drug Use." *Journal of Primary Prevention* 26, no. 6 (2005): 529–51.
- Brown, Sandra A., Matthew McGue, Jennifer Maggs, John Schulenberg, Ralph Hingson, Scott Swartzwelder, Christopher Martin, et al. "A Developmental Perspective on Alcohol and Youths 16 to 20 Years of Age." *Pediatrics* 121, Supplement no. 4 (2008): S290–S310.
- Casey, B. J., Sarah Getz, and Adriana Galvan. "The Adolescent Brain." *Developmental Review* 28, no. 1 (2008): 62–77.
- Centers for Disease Control and Protection. "Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products." US Department of Health and Human Services, February 25, 2020. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html.
- Chambers, R. Andrew, Jane R. Taylor, and Marc N. Potenza. "Developmental Neurocircuitry of Motivation in Adolescence: A Critical Period of Addiction Vulnerability." *American Journal of Psychiatry* 160, no. 6 (2003): 1041–52.
- Chapman, Daniel P., Charles L. Whitfield, Vincent J. Felitti, Shanta R. Dube, Valerie J. Edwards, and Robert F. Anda. "Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood." *Journal of Affective Disorders* 82, no. 2 (2004): 217–25.
- Christie, Kimberly A., Jack D. Burke, Darrel A. Regier, Donald S. Rae, Jeffrey H. Boyd, and Ben Z. Locke. "Epidemiologic Evidence for Early Onset of Mental Disorders and Higher Risk of Drug Abuse in Young Adults." *American Journal of Psychiatry* 145, no. 8 (1988), 971–75. <https://doi.org/10.1176/ajp.145.8.971>
- Crews, Fulton, Jun He, and Clyde Hodge. "Adolescent Cortical Development: A Critical Period of Vulnerability for Addiction." *Pharmacology Biochemistry and Behavior* 86, no. 2 (2007): 189–99.
- Dayan, Peter, and Bernard W. Balleine. "Reward, Motivation, and Reinforcement Learning." *Neuron* 36, no. 2 (2002): 285–98.
- Deas, Deborah, and Suzanne E. Thomas. "An Overview of Controlled Studies of Adolescent Substance Abuse Treatment." *American Journal on Addictions* 10, no. 2 (2001): 178–89.

- Dube, Shanta R., Vincent J. Felitti, Maxia Dong, Daniel P. Chapman, Wayne H. Giles, and Robert F. Anda. "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." *Pediatrics* 111, no. 3 (2003): 564–72.
- Franken, Ingmar H. A., Cornelis J. Stam, Vincent M. Hendriks, and Wim van den Brink. "Neurophysiological Evidence for Abnormal Cognitive Processing of Drug Cues in Heroin Dependence." *Psychopharmacology* 170, no. 2 (2003): 205–12.
- Friedman, Alfred S., Arlene Terras, Weizhong Zhu, and Jean McCallum. "Depression, Negative Self-Image, and Suicidal Attempts as Effects of Substance Use and Substance Dependence." *Journal of Addictive Diseases* 23, no. 4 (2004): 55–71.
- Fuhrmann, Delia, Lisa J. Knoll, and Sarah-Jayne Blakemore. "Adolescence as a Sensitive Period of Brain Development." *Trends in Cognitive Sciences* 19, no. 10 (2015): 558–66.
- Gaiha, Shivani Mathur, Jing Cheng, and Bonnie Halpern-Felsher. "Association Between Youth Smoking, Electronic Cigarette Use, and COVID-19." *Journal of Adolescent Health* 67, no. 4 (2020): 519–23.
- Gardner, Margo, and Laurence Steinberg. "Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study." *Developmental Psychology* 41, no. 4 (2005): 625–35.
- Goto, Yukiori, and Anthony A. Grace. "Dopamine Modulation of Hippocampal–Prefrontal Cortical Interaction Drives Memory-Guided Behavior." *Cerebral Cortex* 18, no. 6 (2008): 1407–14.
- Hedegaard, Holly, Arialdi M. Miniño, and Margaret Warner. "Drug Overdose Deaths in the United States, 1999–2018." NCHS Data Brief No. 356, January 2020. <https://www.cdc.gov/nchs/products/databriefs/db356.htm>.
- Herzberg, David. "Quaalude Nostalgia: A Retro Drug That Everyone Remembers Fondly." *The Atlantic*, February 21, 2012. <https://www.theatlantic.com/health/archive/2012/02/quaalude-nostalgia-a-retro-drug-that-everyone-remembers-fondly/252285/>.
- Jacobus, Joanna, and Susan F. Tapert. "Effects of Cannabis on the Adolescent Brain." *Current Pharmaceutical Design* 20, no. 13 (2014): 2186–93.
- Kandel, Denise B., Jeffrey G. Johnson, Hector R. Bird, Myrna M. Weissman, Sherryl H. Goodman, Benjamin B. Lahey, Darrel A. Regier, and Mary E. Schwab-Stone. "Psychiatric Comorbidity Among Adolescents with Substance Use Disorders: Findings from the MECA Study." *Journal of the American Academy of Child and Adolescent Psychiatry* 38, no. 6 (1999): 693–99.
- Kirke, Deirdre M. "Chain Reactions in Adolescents' Cigarette, Alcohol and Drug Use: Similarity Through Peer Influence or the Patterning of Ties in Peer Networks?" *Social Networks* 26, no. 1 (2004): 3–28.
- Liebschutz, Jane, Jacqueline B. Savetsky, Richard Saitz, Nicholas J. Horton, Christine Lloyd-Travaglini, and Jeffrey H. Samet. "The Relationship Between Sexual and Physical Abuse and Substance Abuse Consequences." *Journal of Substance Abuse Treatment* 22, no. 3 (2002): 121–28.

- Lubman, Dan I., Murat Yücel, and Wayne D. Hall. "Substance Use and the Adolescent Brain: A Toxic Combination?" *Journal of Psychopharmacology* 21, no. 8 (2007): 792–94.
- Melgaard, B., L. Henriksen, P. Ahlgren, U. T. Danielsen, H. Sørensen, and O. B. Paulson. "Regional Cerebral Blood Flow in Chronic Alcoholics Measured by Single Photon Emission Computerized Tomography." *Acta Neurologica Scandinavica* 82, no. 2 (1990): 87–93.
- Monti, Peter M., Tracy O'Leary Tevyaw, and Brian Borsari. "Drinking Among Young Adults: Screening, Brief Intervention, and Outcome." *Alcohol Research and Health* 28, no. 4 (2004): 236–44.
- Muck, Randolph, Kristin A. Zempolich, Janet C. Titus, Marc Fishman, Mark D. Godley, and Robert Schwebel. "An Overview of the Effectiveness of Adolescent Substance Abuse Treatment Models." *Youth and Society* 33, no. 2 (2001): 143–68.
- National Institute on Alcohol Abuse and Alcoholism. "Age of Drinking Onset Predicts Future Alcohol Abuse and Dependence." January 14, 1998. <https://www.niaaa.nih.gov/news-events/news-releases/age-drinking-onset-predicts-future-alcohol-abuse-and-dependence>.
- National Institute on Alcohol Abuse and Alcoholism. "Drugs and the Brain." July 10, 2020. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>.
- National Institute on Alcohol Abuse and Alcoholism. "Parenting to Prevent Childhood Alcohol Use." January 2020. <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/parenting-prevent-childhood-alcohol-use>.
- National Institute on Alcohol Abuse and Alcoholism. "Underage Drinking." Alcohol Alert. January 2006. <https://pubs.niaaa.nih.gov/publications/AA67/AA67.htm>.
- National Institute on Drug Abuse. "Monitoring the Future Survey: High School and Youth Trends DrugFacts." December 18, 2019. <https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends>.
- National Institute on Drug Abuse. "Opioid Overdose Reversal with Naloxone (Narcan, Evzio)." National Institute of Health, February 20, 2020. <https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-reversal-naloxone-narcan-evzio>.
- Robinson, Sean M., and Bryon Adinoff. "The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations." *Behavioral Sciences* 6, no. 3 (2016): 18.
- Robison, Jennifer. "Decades of Drug Use: The 80s and 90s." Gallup, July 9, 2002. <https://news.gallup.com/poll/6352/decades-drug-use-80s-90s.aspx>.
- Romberg, Alexa R., Erin J. Miller Lo, Alison F. Cuccia, Jeffrey G. Willett, Haijun Xiao, Elizabeth C. Hair, Donna M. Vallone, Kristy Marynak, and Brian A. King. "Patterns of Nicotine Concentrations in Electronic Cigarettes Sold in the United States, 2013–2018." *Drug and Alcohol Dependence* 203 (2019): 1–7.

- Rutherford, Helena J. V., Linda C. Mayes, and Marc N. Potenza. "Neurobiology of Adolescent Substance Use Disorders: Implications for Prevention and Treatment." *Child and Adolescent Psychiatric Clinics* 19, no. 3 (2010): 479–92.
- Savin-Williams, Ritch C. *Adolescence: An Ethological Perspective*. Berlin: Springer Science and Business Media, 2012.
- Siegel, Daniel J. *Brainstorm: The Power and Purpose of the Teenage Brain*. London: Penguin, 2015.
- Silveri, Marisa M., and Linda Patia Spear. "Decreased Sensitivity to the Hypnotic Effects of Ethanol Early in Ontogeny." *Alcoholism: Clinical and Experimental Research* 22, no. 3 (1998): 670–76.
- Sinha, Rajita. "How Does Stress Increase Risk of Drug Abuse and Relapse?" *Psychopharmacology* 158, no. 4 (2001): 343–59.
- Somerville, Leah H., Rebecca M. Jones, and B. J. Casey. "A Time of Change: Behavioral and Neural Correlates of Adolescent Sensitivity to Appetitive and Aversive Environmental Cues." *Brain and Cognition* 72, no. 1 (2010): 124–33.
- Spear, Linda P. "Alcohol Consumption in Adolescence: A Translational Perspective." *Current Addiction Reports* 3, no. 1 (2016): 50–61.
- Squeglia, Lindsay M., Joanna Jacobus, and Susan F. Tapert. "The Influence of Substance Use on Adolescent Brain Development." *Clinical EEG and Neuroscience* 40, no. 1 (2009): 31–38.
- Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, August 2019. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.
- Substance Abuse Mental Health Services Administration. *Summary of Findings from the 1998 National Household Survey on Drug Abuse*. Washington, DC: US Department of Health and Human Services, 1999.
- Substance Abuse and Mental Health Services Administration. "2018 National Survey of Drug Use and Health (NSDUH) Releases: CBHSQ Data." US Department of Health and Human Services. Accessed August 12, 2020. <https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases>.
- Trimarchi, Aria, and Ann Meeker-O'Connell. "How Nicotine Works." How Stuff Works, January 2, 2001. <https://science.howstuffworks.com/nicotine1.htm>.
- US Food and Drug Administration. "2018 NYTS Data: A Startling Rise in Youth E-Cigarette Use." May 4, 2020. <https://www.fda.gov/tobacco-products/youth-and-tobacco/2018-nyts-data-startling-rise-youth-e-cigarette-use>.
- Waelti, Pascale, Anthony Dickinson, and Wolfram Schultz. "Dopamine Responses Comply with Basic Assumptions of Formal Learning Theory." *Nature* 412, no. 6842 (2001): 43–48.

- Weiss, Isabelle C., Annette M. Domeney, Christian A. Heidbreder, Jean-Luc Moreau, and Joram Feldon. "Early Social Isolation, but Not Maternal Separation, Affects Behavioral Sensitization to Amphetamine in Male and Female Adult Rats." *Pharmacology Biochemistry and Behavior* 70, nos. 2–3 (2001): 397–409.
- Wills, Thomas Ashby, Donato Vaccaro, and Grace McNamara. "Novelty Seeking, Risk Taking, and Related Constructs as Predictors of Adolescent Substance Use: An Application of Cloninger's Theory." *Journal of Substance Abuse* 6, no. 1 (1994): 1–20.
- Windle, Michael. "Drinking over the Lifespan: Focus on Early Adolescents and Youth." *Alcohol Research: Current Reviews* 38, no. 1 (2016): 95-101.

Chapter 9

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013.
- Anderson, Monica, and Jingjing Jiang. "Teens, Social Media, and Technology 2018." *Pew Research Center* 31 (2018). <https://www.pewresearch.org/internet/2018/05/31/teens-social-media-technology-2018/>.
- Anderson, Monica, and Jingjing Jiang. "Teens' Social Media Habits and Experiences." *Pew Research Center* 28 (2018). https://www.pewresearch.org/internet/wp-content/uploads/sites/9/2018/11/PI_2018.11.28_teens-social-media_FINAL4.pdf.
- Floros, Georgios D. "Gambling Disorder in Adolescents: Prevalence, New Developments, and Treatment Challenges." *Adolescent Health, Medicine and Therapeutics* 9 (2018): 43-51.
- Gentile, Douglas. "Pathological Video-Game Use Among Youth Ages 8 to 18: A National Study." *Psychological Science* 20, no. 5 (2009): 594-602.
- Ghose, T. "Pediatricians: No More Than 2 Hours Screen Time Daily for Kids." *Scientific American*, October 28, 2013. <https://www.scientificamerican.com/article/pediatricians-no-more-than-2-hour-screentime-kids>.
- Hunt, Melissa G., Rachel Marx, Courtney Lipson, and Jordyn Young. "No More FOMO: Limiting Social Media Decreases Loneliness and Depression." *Journal of Social and Clinical Psychology* 37, no. 10 (2018): 751-68.
- Jiang, Jingjing. "How Teens and Parents Navigate Screen Time and Device Distractions." *Pew Research Center for Internet and Technology*, August 22, 2018. <http://www.pewinternet.org/2018/08/22/how-teens-and-parents-navigate-screen-time-and-device-distractions>.
- Orben, Amy, and Andrew K. Przybylski. "The Association Between Adolescent Well-Being and Digital Technology Use." *Nature Human Behaviour* 3, no. 2 (2019): 173-82.
- Twenge, Jean M. "Have Smartphones Destroyed a Generation?" *The Atlantic*, September 2017. <https://www.theatlantic.com/magazine/archive/2017/09/has-the-smartphone-destroyed-a-generation/534198/>.
- Twenge, Jean M., and W. Keith Campbell. "Associations Between Screen Time and Lower Psychological Well-Being Among Children and Adolescents: Evidence from a Population-Based Study." *Preventive Medicine Reports* 12 (2018): 271-83.
- Twenge, Jean M., Brian H. Spitzberg, and W. Keith Campbell. "Less In-Person Social Interaction with Peers Among US Adolescents in the 21st Century and Links to Loneliness." *Journal of Social and Personal Relationships* 36, no. 6 (2019): 1892-913.
- World Health Organization. "Addictive Behaviours: Gaming Disorder." September 14, 2018. <https://www.who.int/news-room/q-a-detail/addictive-behaviours-gaming-disorder>.

Chapter 10

- Afifi, Tracie O., Natalie Mota, Jitender Sareen, and Harriet L. MacMillan. "The Relationships Between Harsh Physical Punishment and Child Maltreatment in Childhood and Intimate Partner Violence in Adulthood." *BMC Public Health* 17, no. 1 (2017): 493.
- Anderson, M. "A Majority of Teens Have Experienced Some Form of Cyberbullying." Pew Research Center, September 27, 2018. <https://www.pewresearch.org/internet/2018/09/27/a-majority-of-teens-have-experienced-some-form-of-cyberbullying/>.
- Anderson, M., and Jingjing Jiang. "Teens and Their Experiences on Social Media." Pew Research Center, November 28, 2018. <https://www.pewresearch.org/internet/2018/11/28/teens-and-their-experiences-on-social-media/>.
- Bradshaw, Catherine P., Anne L. Sawyer, and Lindsey M. O'Brennan. "Bullying and Peer Victimization at School: Perceptual Differences Between Students and School Staff." *School Psychology Review* 36, no. 3 (2007): 361–82.
- Centers for Disease Control and Prevention. "Preventing Bullying." October 21, 2020. <https://www.cdc.gov/violenceprevention/youthviolence/bullyingresearch/fastfact.html>.
- Davis, Stan, and Charisse Nixon. "The Youth Voice Project." *Preliminary Results from the Youth Voice Project: Victimization and Strategies* (2010). <https://njbullying.org/documents/YVPMarch2010.pdf>
- George, Madeleine J., and Candice L. Odgers. "Seven Fears and the Science of How Mobile Technologies May Be Influencing Adolescents in the Digital Age." *Perspectives on Psychological Science* 10, no. 6 (2015): 832–51.
- Gini, Gianluca, and Dorothy L. Espelage. "Peer Victimization, Cyberbullying, and Suicide Risk in Children and Adolescents." *JAMA* 312, no. 5 (2014): 545–46.
- Gini, Gianluca, and Tiziana Pozzoli. "Bullied Children and Psychosomatic Problems: A Meta-Analysis." *Pediatrics* 132, no. 4 (2013): 720–29.
- Gladden, R. M., A. M. Vivolo-Kantor, M. E. Hamburger, and C. D. Lumpkin. *Bullying Surveillance Among Youths: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention and US Department of Education, 2014.
- Golding, William. *Lord of the Flies*. London: Penguin, 1987.
- Guardchild. "Teenage Sexting Statistics." Accessed December 20, 2020. <https://www.guardchild.com/teenage-sexting-statistics/>.
- Hawkins, Lynn D., Debra J. Pepler, and Wendy M. Craig. "Naturalistic Observations of Peer Interventions in Bullying." *Social Development* 10, no. 4 (2001): 512–27.
- i-SAFE Inc. "i-SAFE Inc." Accessed December 20, 2020. https://auth.isafe.org/outreach/media/media_cyber_bullying.

- Kosciw, Joseph G., Emily A. Greytak, Adrian D. Zongrone, Caitlin M. Clark, and Nhan L. Truong. *The 2017 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools*. New York: Gay, Lesbian and Straight Education Network (GLSEN), 2018.
- Rose, Chad A., and Dorothy L. Espelage. "Risk and Protective Factors Associated with the Bullying Involvement of Students with Emotional and Behavioral Disorders." *Behavioral Disorders* 37, no. 3 (2012): 133–48.
- Yanez, C., and M. Seldin. *Student Reports of Bullying: Results from the 2017 School Crime Supplement to the National Crime and Victimization Survey* (NCES 2019-054). July 2019. US Department of Education. Washington, DC: National Center for Education Statistics. <https://nces.ed.gov/pubs2019/2019054.pdf>.

Chapter 11

Blos, Peter. "The Second Individuation Process of Adolescence." *The Psychoanalytic Study of the Child* 22, no. 1 (1967): 162-86.

Chapter 12

Freud, Sigmund. "Remembering, Repeating and Working-Through." *Internationale Zeitschrift für Psychoanalyse* 2 (1914): 485-91.

Library of Congress Cataloging-in-Publication Data is available through the Library of Congress

© 2021 Erica Komisar

ISBN-13: 978-0-7573-2400-0 (Paperback)

ISBN-10: : 0-7573-2400-2 (Paperback)

ISBN-13: 978-0-7573-2401-7 (ePub)

ISBN-10: 0-7573-2401-0 (ePub)

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Publisher: Health Communications, Inc.

1700 NW 2nd Avenue

Boca Raton, FL 33432-1653

Cover and interior design by Larissa Hise Heno

Interior formatting by Lawna Patterson Oldfield

Author photo by Britney Young



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